Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Lifeline Specialty Pharmacy Crohn's/GI/UC Prescription Referral Form (S-Z)

6304 Woodside Ct, Ste 100
Columbia, MD 21046

LIFELINE SPECIALTY PHARMACY

Send your Rx to: **Phone: 1-833-4-LIFELINE (1-833-454-3354)**
Fax: 1-833-785-4461

NPI: 1568975464

If you have questions or concerns, please contact us.

Date Medication Needed:_____ **Ship To:** ☐ Patient's Home ☐ Prescriber's Office ☐ Pick-up (store location):_____ Injection training by pharmacy? ☐

1: Patient Information

Patient Name:_____ **Birthdate:**_____ **Sex:** ☐ Male ☐ Female **Height:**____ **Weight:**_____ ☐ lbs. ☐ kg.

Soc. Sec. #:_____ **Preferred Phone:**_____ **Known Allergies:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Alternate Caregiver Name:_____ **Preferred Phone:**_____

2: Insurance Information

Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Primary Prescription Insurance_____ **Rx Bin**_____

Rx PCN_____ **Patient ID/Policy Number**_____ **Patient Rx Group Number**_____

3: Prescriber Information

Provider Name:_____ **DEA#:**_____ **NPI#:**_____ **Tax ID#:**_____

Address:_____ **Phone:**_____ **Fax:**_____

City, State, Zip:_____ **Key Contact:**_____ **Phone:**_____

4: Diagnosis/Clinical Information

Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization

Diagnosis:_____ **ICD-10:**_____

Patient Support and Injection Training Authorization

I authorize Lifeline Specialty Pharmacy to enroll the patient in the pharmaceutical manufacturer support program that pertains to the prescribed therapy. The purpose of this enrollment is to assist the patient in receiving services, like injection training and administration of the therapy by a nurse. The patient also authorizes the pharmacy to transmit any pertinent information that the manufacturer needs to effectively provide the medications and services that are available with the therapy, as well as, to use unidentifiable data to conduct market research. The manufacturer may contact me with information for research and educational purposes. The patient can revoke this authorization without any effect to the patient's ability to acquire the therapy. If the patient chooses to revoke this authorization, he/she may do so by writing a letter to Lifeline Specialty Pharmacy at 3233 Corporate Court, Ellicott City, MD, 21042 .

5: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Simponi®**	☐ 100 mg Smartject ☐ 100 mg Prefilled Syringe	☐ **Induction Dose**: Inject 200 mg SC at weeks 0, then inject **100 mg SC at week 2** ☐ **Maintenance Dose**: Inject 100 mg SC every 4 weeks		
☐ **Skyrizi®**	☐ 600 mg Vial ☐ 180 mg/1.2 mL OBI ☐ 360/2.4 mL OBI	☐ **Induction Dose**: Infuse 600 mg via IV at week 0, week 4, and week 8 ☐ Inject 180 mg SC at week 12 and every 8 weeks thereafter ☐ Inject 360 mg SC at week 12 and every 8 weeks thereafter ☐ Other: _____		
☐ **Stelara Starter Dose®**	☐ 2 x 130 mg/26 mL ☐ 3 x 130 mg/26 mL ☐ 4 x 130 mg/26 mL	</= 55kg: ☐ Infuse 260mg IV as induction dose over at least 1 hour > 55kg to </= 85kg: ☐ Infuse 390 mg IV as induction dose over at least 1 hour > 85 kg: ☐ Infuse 520mg IV as induction dose over at least 1 hour ☐ Low-dose induction: Infuse 130 mg IV over at least 1 hour		
☐ **Stelara®**	☐ 1 x 90 mg/ml PFS	☐ Inject 90 mg SC 8 weeks after initial IV dose and then every 8 weeks thereafter		
☐ **Tysabri®**	☐ 300 mg/15 mL	☐ Infuse 300 mg IV over 1 hour every 4 weeks		
☐ **Xeljanz/XR®**	☐ 5 mg Tablet ☐ 10 mg Tablet ☐ 11 mg Tablet ☐ 22 mg Tablet	**Induction Doses:** ☐ Take 10mg by mouth twice daily for ____ weeks ☐ Take 22mg by mouth once daily for ____ weeks **Maintenance Doses:** ☐ Take 5 mg by mouth twice daily ☐ Take 11 mg by mouth once daily		
☐ **Xifaxan®**	☐ 200 mg Tablet ☐ 550 mg Tablet	☐ Take ____ tablets by mouth ____ times per day		
☐ **Zeposia®**	☐ Starter Pack ☐ 0.92 mg Capsule	☐ Titration: Take 0.23 mg by mouth on week 0 and advance as directed ☐ Maintenance Dose: Take 0.92 mg by mouth once daily		
☐ Other:				

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: Date:

Prescriber Signature: Prescriber, please sign and date below

Dispense as written Date Substitution Permissible Date

# of Prescriptions: _____