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

Hepatitis B Prescription Referral Form

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:**____ :_____ ☐ 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**_____

2: Prescriber Information

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

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

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

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

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

4: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Baraclude®**	☐ 0.5mg ☐ 1mg ☐ 0.05mg/ml:	☐ 0.5mg tab by mouth daily ☐ 1mg tab by mouth daily ☐ **Other:**	☐ 30 ☐ ml	
☐ **Epivir HBV**	☐ 100mg	☐ 100mg by mouth daily	30	
☐ **Hepsera®**	☐ 10mg	☐ 10mg by mouth daily	30	
☐ **HBIG** (Hepatitis B Immune Globulin - single use vial)				
☐ **Pegasys®** ☐ Prefilled Syringe ☐ Vial ☐ ProClick®	☐ 180mcg ☐ 135mcg	☐ 180 mcg SQ once weekly ☐ 90 mcg SQ once weekly ☐ 135 mcg SQ once weekly	28 day supply	
☐ **Vemlidy®**	☐ 25mg	☐ 25mg by mouth daily with food	30	
☐ **Viread®**	☐ 300mg	☐ 300mg by mouth daily ☐ **Other:**	30	
☐				
☐				
☐				
☐				
☐				

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

Substitution Permissible Date Dispense as written Date

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. **Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.**

# of Prescriptions: _____