

Lifeline Specialty Pharmacy

Hepatitis B Prescription Referral Form

3233 Corporate Ct.
Ellicott City, MD 21043



Send your Rx to:

Fax Number: 410-203-1515
Phone Number: 410-203-1010

Toll Free Number:
1-833-4-LIFELINE

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
<input type="checkbox"/> Baraclude®	<input type="checkbox"/> 0.5mg <input type="checkbox"/> 1mg <input type="checkbox"/> 0.05mg/ml:	0.5mg tab by mouth daily 1mg tab by mouth daily <input type="checkbox"/> Other:	30 ml	
<input type="checkbox"/> Epivir HBV	<input type="checkbox"/> 100mg	<input type="checkbox"/> 100mg by mouth daily	30	
<input type="checkbox"/> Hepsera®	<input type="checkbox"/> 10mg	<input type="checkbox"/> 10mg by mouth daily	30	
<input type="checkbox"/> HBIG (Hepatitis B Immune Globulin - single use vial)				
<input type="checkbox"/> Pegasys® <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Vial <input type="checkbox"/> ProClick®	<input type="checkbox"/> 180mcg <input type="checkbox"/> 135mcg	<input type="checkbox"/> 180 mcg SQ once weekly <input type="checkbox"/> 90 mcg SQ once weekly <input type="checkbox"/> 135 mcg SQ once weekly	28 day supply	
<input type="checkbox"/> Vemlidy®	<input type="checkbox"/> 25mg	<input type="checkbox"/> 25mg by mouth daily with food	30	
<input type="checkbox"/> Viread®	<input type="checkbox"/> 300mg	<input type="checkbox"/> 300mg by mouth daily <input type="checkbox"/> Other:	30	
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

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: _____