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

Rheumatoid Arthritis Prescription Referral Form (O-Z)

6304 Woodside Ct, Ste 100
Columbia, MD 21046

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:**________________

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

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 Code**______________ **Is patient currently on RA therapy?** ☐ **Yes** ☐ **No**

TB/PPD test given? ☐ Yes ☐ No Serious/Active Infection? ☐ Yes ☐ No Medications:____________________________

☐ **Prior failed medications** (medication and duration of treatment/reason for d/c)________________________________

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 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 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 do so by writing a letter to Lifeline Specialty Pharmacy at 3233 Corporate Court, Ellicott City, MD, 21042 .

4: Prescription Information | *Xeljanz NOT to be used in combination with biologic DMARD's*

Medication	Dose/Strength	Sig	Qty.	Refills
Olumiant	2mg	Take 1 tablet by mouth daily		
Orencia	125mg ClickJet 125 mg PFS	Inject 125 mg SC once a week		
	250mg Vials	Infuse___mg at______________________		
Otezla	Titration Starter Pack	Use Titration Starter Pack as directed		
	30mg Tablet	Maintenance Dose: Take one 30mg tablet orally twice daily		
Otrexup	12.5mg 15mg 17.5mg 20mg 22.5mg 25mg	Inject _____ mg SQ weekly		
Pen Needles	31 gauge 6mm			
Rasuvo	7.5mg/0.15ml 10mg/0.2ml 12.5mg/0.25ml 15mg/0.3ml 17.5mg/0.35ml 20mg/0.4ml 22.5mg/0.4ml 25mg/0.5ml 30mg/0.6ml	Inject _____ mg SQ weekly		
Remicade	100 mg Vials	Infuse _____ mg at week 0, 2, 6, and then every 8 weeks thereafter Infuse _____ mg SQ every _____ weeks		
Rinvoq	15 mg tablet	Take one tablet by mouth daily		
Rituxan	100mg/10ml 500mg/50ml	Infuse ___mg IV every ___ weeks, repeat ____mg every ___ months Other: ______________________		
Simponi	50 mg SmartJet 50 mg PFS Aria 100 mg SmartJet 100 mg PFS	Infuse ____ mg once a month as directed Infuse ____ mg at weeks 0, 2, and 6 and every 8 weeks thereafter		
Stelara	45mg PFS (<100kg) 90mg PFS (>100kg)	Inject ____ mg on day 0, then 4 weeks, then every 12 weeks Inject ____ mg SC every ____ weeks		
Taltz	80mg Auto 80mg PFS	Inject 160mg on day 1, then 80mg every ____ weeks Maintenance Dose: Inject 80 mg SC every 4 weeks		
Tremfya	100 mg PFS 100 mg Auto	Starting Dose: Inject 100 mg SC at weeks 0 and 4 Maintenance Dose: Inject 100 mg SC every 8 weeks		
Yuflyma	40mg/0.4ml Auto 40mg/0.4ml PFS	Inject ____mg SC every other week Inject 80mg SC once, then 40mg every other week Inject 160mg on day 1, 80mg on day 15, then ___mg every ___week		
Yusimry	40mg/0.8ml			
Xeljanz	5mg Tablets 10mg Tablets	Take 1 tablet by mouth twice daily		
Xeljanz XR	11mg Tablets	Take 1 tablet by mouth daily		

Patient Signature: Date:

Prescriber Signature: Prescriber, please sign and date below

Dispense as written ______ Date ______ Substitution Permissible ______ 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: