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

MS Prescription Referral Form

3233 Corporate Ct.
Ellicott City, MD 21042

LIFELINE SPECIALTY PHARMACY

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:** _____ **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: CM G35 Multiple Sclerosis ☐ **Other:** _____

Has the patient been previously treated for this condition? ☐ Yes ☐ No

Prior failed medication (medication and duration of treatment/reason for d/c):

☐ _____

Number of relapses in past year: _____

Last MRI date: _____ **Any MRI changes?** ☐ Yes ☐ No

Inection training completed by:

Patient currently on therapy? ☐ Yes ☐ No Medication(s): _____

Will medication be stopped before starting new therapy? ☐ Yes ☐ No Is prescriber a Neurologist? ☐ Yes ☐ No If no, include neurology consult if available. **Diagnosis:** _____

5: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Avonex®**	☐ AVOSTARTGRIP Titration Kit ☐ 30mcg Prefilled Syringe #4 ☐ 30mcg Pen #4	☐ **Dose Titration:** • Week 1: Inject 7.5mcg IM once weekly • Week 2: Inject 15mcg IM once weekly • Week 3: Inject 22.5mcg IM once weekly • Week 4+: Inject 30mcg IM once weekly ☐ Inject 30mcg IM once weekly	4 week supply	----------
☐ **Betaseron®**	☐ 0.3mg vial	☐ **Dose Titration:** • Week 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD • Week 3-4: Inject 0.125mg/0.50ml subcutaneously QOD • Week 5-6: Inject 0.1875 mg/0.75 subcutaneously QOD • Week 7+: Inject 0.25mg/1ml subcutaneously QOD ☐ **Maintenance Dose:** 0.25mg /1ml subcutaneously QOD ☐ **Other:**	4 week supply	----------
☐ **Copaxone®**	☐ 20mg Prefilled Syringe ☐ 40mg Prefilled Syringe	☐ 20mg SQ QD ☐ 40mg SQ 3 times a week, at least 48 hours apart on the same 3 days each week	4 week supply	
☐ **Extavia®**	☐ 0.3mg vial	☐ **Dose Titration:** • Weeks 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD • Weeks 3-4: Inject 0.125mg/0.50ml subcutaneously QOD • Weeks 5-6: Inject 0.1875mg/0.75 subcutaneously QOD • Weeks 7+: Inject 0.25mg/1ml subcutaneously QOD ☐ **Maintenance Dose:** 0.25mg /1ml subcutaneously QOD ☐ **Other:**	4 week supply	----------
☐ **Glatopa®**	☐ 20mg Prefilled Syringe	☐ 20mg SQ QD	4 week supply	
☐ **Gilenya®**	☐ 0.5mg capsule	☐ Take 0.5mg po QD	4 week supply	
☐ **Rebif®** ☐ **Rebif Redidose®**	☐ Titration Pack (8.8mcg/22mcg) ☐ 22mcg Prefilled Syringe ☐ 44mcg Prefilled Syringe	☐ Inject 8.8mcg subcutaneously three times a week weeks 1-2, 22mcg subcutaneously three times a week weeks 3-4, and 44mcg subcutaneously three times a week weeks 5+ (48 hours apart) ☐ **Maintenance:** Inject 22mcg (0.5ml) SQ three times a week (48 hours apart) ☐ **Maintenance:** Inject 44mcg (0.5ml) SQ three times a week (48 hours apart) ☐ **Other:**	4 week supply	----------

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: _____