



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

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 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.

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

| Medication | Dose/Strength | Formulation | Sig | Qty. | Refills |
|---|--|--|--|------|---------|
| <input type="checkbox"/> Actemra | <input type="checkbox"/> 162mg <input type="checkbox"/> _____ Vial | <input type="checkbox"/> Pen <input type="checkbox"/> Prefilled Syringe | <input type="checkbox"/> Inject 162mg SC <input type="checkbox"/> once a week or <input type="checkbox"/> every other week <input type="checkbox"/> Inject _____ mg every 4 weeks | | |
| <input type="checkbox"/> Amjevita | <input type="checkbox"/> 10mg/0.2ml <input type="checkbox"/> 20mg/0.4ml <input type="checkbox"/> 40mg/0.8ml | <input type="checkbox"/> PFS <input type="checkbox"/> PFS <input type="checkbox"/> Sureclick Pen | <input type="checkbox"/> Inject _____ mg SC every other week <input type="checkbox"/> Inject _____ mg on Day 1, _____ mg on Day 15, then _____ mg every _____ week <input type="checkbox"/> Inject 80mg SC once, then 40mg every other week starting Day 8 | | |
| <input type="checkbox"/> Cimzia | <input type="checkbox"/> 200mg | <input type="checkbox"/> Starter Kit <input type="checkbox"/> SDV <input type="checkbox"/> Prefilled Syringe | <input type="checkbox"/> Induction Dose: Inject 400mg SC on Day 0, at week 2, & week <input type="checkbox"/> Inject _____ mg SC once every _____ weeks | | |
| <input type="checkbox"/> Cosentyx | <input type="checkbox"/> 150mg | <input type="checkbox"/> PFS <input type="checkbox"/> Sensoready Pen | <input type="checkbox"/> Inject _____ mg SC every _____ weeks | | |
| <input type="checkbox"/> Cytezo | <input type="checkbox"/> 10mg/0.2ml <input type="checkbox"/> 20mg/0.4ml <input type="checkbox"/> 40mg/0.8ml | <input type="checkbox"/> PFS <input type="checkbox"/> PFS <input type="checkbox"/> Pen | <input type="checkbox"/> Inject _____ mg SC every other week <input type="checkbox"/> Inject _____ mg on Day 1, _____ mg on Day 15, then _____ mg every _____ week <input type="checkbox"/> Inject 80mg SC once, then 40mg every other week starting Day 8 | | |
| <input type="checkbox"/> Enbrel | <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg | <input type="checkbox"/> PFS <input type="checkbox"/> Vials <input type="checkbox"/> Sureclick <input type="checkbox"/> Syringe <input type="checkbox"/> Mini | <input type="checkbox"/> Inject _____ mg SC _____ a week <input type="checkbox"/> (72-96 hours apart) | | |
| <input type="checkbox"/> Hadlima | <input type="checkbox"/> 40mg/0.4ml <input type="checkbox"/> 40mg/0.8ml | <input type="checkbox"/> Autoinjector <input type="checkbox"/> Prefilled Syringe | <input type="checkbox"/> Inject _____ mg SC every other week <input type="checkbox"/> Inject 80mg SC once, then 40mg every other week starting Day 8 | | |
| <input type="checkbox"/> Hulio | <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg | <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Pen <input type="checkbox"/> Prefilled Syringe | <input type="checkbox"/> Inject 160mg on day 1, 80mg on day 15, then _____ mg every _____ week | | |
| <input type="checkbox"/> Humira <input type="checkbox"/> CF | <input type="checkbox"/> 40mg | <input type="checkbox"/> Pen <input type="checkbox"/> Prefilled Syringe | <input type="checkbox"/> Inject 40mg SC every _____ weeks | | |
| <input type="checkbox"/> Hyrimoz | <input type="checkbox"/> 10mg <input type="checkbox"/> 40mg <input type="checkbox"/> 20mg <input type="checkbox"/> 80mg <input type="checkbox"/> 80+40mg | <input type="checkbox"/> PFS <input type="checkbox"/> Pen <input type="checkbox"/> Starter Kit | <input type="checkbox"/> Inject _____ mg SC every other week <input type="checkbox"/> Inject 80mg SC once, then 40mg every other week starting Day 8 <input type="checkbox"/> Inject 160mg on day 1, 80mg on day 15, then _____ mg every _____ week | | |
| <input type="checkbox"/> Idacio | <input type="checkbox"/> 40mg/0.8ml | <input type="checkbox"/> PFS <input type="checkbox"/> Pen | <input type="checkbox"/> Infuse _____ mg at week 0, 2, 6, and then every 8 weeks thereafter <input type="checkbox"/> Infuse _____ mg SC every _____ weeks | | |
| <input type="checkbox"/> Inflectra | <input type="checkbox"/> 100mg | <input type="checkbox"/> Vials | <input type="checkbox"/> Infuse _____ mg at week 0, 2, 6, and then every 8 weeks thereafter <input type="checkbox"/> Infuse _____ mg SC every _____ weeks | | |
| <input type="checkbox"/> Kevzara | <input type="checkbox"/> 150mg <input type="checkbox"/> 200mg | <input type="checkbox"/> Pen <input type="checkbox"/> PFS | <input type="checkbox"/> Inject 1 pen or syringe SC every 2 weeks | | |

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

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: _____