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

Pediatric GI/Crohn's/UC 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:**____ **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:_____ **ICD-10:**_____

5: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Humira® (Citrate Free)** **Pt less than 40kg**	☐ **Humira® Starter Pack**	Inject 80mg SC day 1, then 40mg SC on day 15		
	☐ **20mg PFS**	Inject 20 mg SC every other week		
☐ **Humira® (Citrate Free)** **Pt less than 40kg**	☐ **Humira® Starter Pack**	Inject 160mg SC on day 1, then 80mg SC on day 15		
	☐ **40mg Pen** ☐ **40mg PFS**	Inject 40mg SC every other week		
☐ **Remicade**	☐ **100mg vials**	Infuse 5mg/kg at week 0, 2, and 6. Then infuse 5mg/kg every 8 weeks		
☐ **Other**_____	☐			
Topical Injection Pain Relief				
☐ **Synera**	☐ **Synera Patch** (lidocaine and tetracaine)	Apply 1 patch to injection site 20-30 minutes before administration		

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

I authorize Lifeline Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

# of Prescriptions:_____