



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: \_\_\_\_\_ ICD-10: \_\_\_\_\_

**5: Prescription Information**

Medication	Dose/Strength	Sig	Qty.	Refills
<input type="checkbox"/> Humira® (Citrate Free) Pt less than 40kg	<input type="checkbox"/> Humira® Starter Pack	Inject 80mg SC day 1, then 40mg SC on day 15		
	<input type="checkbox"/> 20mg PFS	Inject 20 mg SC every other week		
<input type="checkbox"/> Humira® (Citrate Free) Pt less than 40kg	<input type="checkbox"/> Humira® Starter Pack	Inject 160mg SC on day 1, then 80mg SC on day 15		
	<input type="checkbox"/> 40mg Pen	Inject 40mg SC every other week		
	<input type="checkbox"/> 40mg PFS			
<input type="checkbox"/> Remicade	<input type="checkbox"/> 100mg vials	Infuse 5mg/kg at week 0, 2, and 6. Then infuse 5mg/kg every 8 weeks		
<input type="checkbox"/> Other _____	<input type="checkbox"/>			
<b>Topical Injection Pain Relief</b>				
<input type="checkbox"/> Synera	<input type="checkbox"/> 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 \_\_\_\_\_

Authorize Lifeline Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.  
**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: \_\_\_\_\_