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

Crohn's / GI / UC 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. ☐ g.

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:**_____

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 .

5: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Cimzia®**	☐ Prefilled Syringes (2x200mg) ☐ Lyophilized vials (2 x 200mg)	**Starter Dose**: ☐ Inject 400mg SC at weeks 0, 2, and 4 **Maintenance Dose:** ☐ 400mg SC every 4 weeks	_____ _____	0 _____
☐ **Humira®** ☐ **Humira® (Citrate Free)**	☐ 20mg Pen ☐ 20mg PFS ☐ 40mg Pen ☐ 40mg PFS ☐ Starter Pack	**Starter Dose**: ☐ Inject 160mg SC for first Dose (Day 1). Then Inject 80mg SC two weeks after first dose (Day 15). Then inject 40mg SC every OTHER week starting at week 4 (Day 29) **Maintenance Dose:** ☐ Inject 40mg SC (one 40mg Pen) every other week ☐ Other: _____	_____ _____ _____	0 _____ _____
☐ **Xifaxan®**	☐ 200mg tabs ☐ 550mg tabs	Take _____ tablets _____ times per day		
☐ **Remicade®**	☐ 100mg vial	☐ Infuse 100 mg IV at at 0, 2 and 6 weeks, and then every 8 weeks thereafter ☐ Other: _____		
☐ **Simponi®**	☐ 100mg SmartJect® ☐ 100mg Prefilled Syringe	☐ **Starter Dose**: Inject 200mg SC at week 0, then 100mg SC at week 2, then start maintenance at week 6 ☐ **Maintenance Dose:** 100mg SC every 4 weeks starting at week 6, after Induction dose	3 1	0 _____
☐ **Entyvio®**	☐ 300mg vial	☐ Infuse 300 mg IV at 0, 2, and 6 weeks and every 8 weeks thereafter		
☐ **Dificid®**	☐ 200mg tabs	☐ Take 1 tablet twice daily with or without food for 10 days	20 Tablets	
☐ **Stelara® Starter Dose**	☐ 2x 130mg/26ml ☐ 3x 130mg/26ml ☐ 4x 130mg/26ml	</=55kg ☐ Infuse 260mg IV as induction dose over at least 1 hour >55kg to </=85kg ☐ Infuse 390mg IV as induction dose over at least 1 hour >85kg ☐ Infuse 520mg IV as induction dose over at least 1 hour ☐ Low-dose induction: Infuse 130mg IV over at least 1 hour	_____ vials	0
☐ **Stelara®**	☐ 1x 90mg/ml Prefilled Syringe	☐ Inject 90mg SC 8 weeks after initial IV dose and then every 8 weeks thereafter	1x90mg/ml PFS	
☐ **Tysabri®**	☐ 300mg/15 ml	☐ Infuse 300 mg IV over 1 hour every 4 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 Permissable 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: _____