



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

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

Provider Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Key Contact: _____ Phone: _____

Office Contact Name: _____ Phone Number: _____ CoverMyMeds Email: _____

Please fax recent clinical notes, labs/rounding reports with this prescription to expedite the prior authorization process if necessary. We complete prior authorizations through CoverMyMeds. Please include the contact email for you or your prescriber's CoverMyMeds account to receive key numbers as we may need to send for the final submission. If you do not have a CoverMyMeds account please reach out to us here at the pharmacy and we will assist in creating new accounts.

3: Diagnosis/Clinical Information

Diagnosis: _____ ICD-10 Code: _____ Prior failed medications _____

4: 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
Neoral	25 mcg/ml 40 mcg/ml	25 mcg/0.42 ml Take ____ capsule(s) by mouth twice a day Take ____ capsule(s) by mouth twice a day		
Phoslyra	667 mg/5 ml	Take 10 ml by mouth with each meal Take ____ ml by mouth ____ times a day with meals		
Procrit	2000 u/ml 3000 u/ml 4000 u/ml	10000 u/ml 20000 u/ml (1 ml vial) 10000 u/ml (2 ml vial) Inject ____ ml SC once a week Inject ____ ml three times a week Inject ____ ml SC every ____ weeks		
Rapamune	0.5 mg 1 mg	2 mg 1mg/ml Take 1 tablet by mouth once daily Take ____ tablet(s) by mouth ____ times a day Take ____ ml by mouth ____ times a day Other: _____		
Renagel	400 mg	800 mg Take 1 tablet by mouth three times a day with meals Take ____ tablet(s) by mouth ____ times a day with meals		
Renvela (Sevelamer)	800 mg	0.8 g packet 2.4 gm packet Take 1 tablet by mouth three times a day with meals Take ____ tablet(s) by mouth ____ times a day with meals Dissolve ____ packet(s) in minimum 2 ounces of water and drink ____ times a day		
Retacrit	2000 u/ml SDV 3000 u/ml SDV 4000 u/ml SDV	10000 u/ml SDV 40000 u/ml SDV Inject ____ ml SC once a week Inject ____ ml SC three times a week Inject ____ ml SC every ____ weeks		
Sandimmune	25 mg	100 mg Take ____ capsule(s) by mouth ____ times a day		
Sensipar	30 mg 60 mg	90 mg Take 1 tablet by mouth once daily with food Take ____ tablet(s) by mouth ____ times a day with food		
Velphoro	500 mg	Chew ____ tablet(s) by mouth ____ times a day with food		
Zortress	0.25 mg 0.5 mg 0.75 mg	Take 1 tablet(s) by mouth two times a day Take ____ tablet(s) by mouth ____ times a day		

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: _____