



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: _____

3: Diagnosis/Clinical Information | Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization

- | | | |
|--|--|---|
| C91.10 Chronic lymphocytic leukemia of B-cell type not having achieved remission | D81.89 Other combined immunodeficiencies | G35 MS (Relapsing Remitting) |
| D69.3 Immune thrombocytopenic purpura | D81.9 SCID (Unspecified) | G61.0 GBS |
| D80.0 Congenital Hypogam | D82.0 Wiskott-Aldrich syndrome | G61.81 CIPD |
| D80.2 Selective deficiency of IgA | D82.1 De George's syndrome | G61.89 MMN |
| D80.4 Selective deficiency of IgM | D82.4 Hyperimmunoglobulin E syndrome | G70.00 MG without acute exacerbation G70.01 |
| D80.5 Immunodeficiency with increased IgM | D83.0 Common Variable Immunodeficiency with Predominant abnormalities of B cell numbers and function | MG with acute exacerbation |
| D80.6 Antibody deficiency with near-normal immunoglobulins or with hyperimmunoglobulinemia | D83.1 Common Variable Immunodeficiency with predominant Immunoregulatory T cell disorders | M33.20 Polymyositis |
| D80.7 Transient hypogammaglobulinemia | D83.2 Common Variable Immunodeficiency with autoantibodies to B or T cells | M33.90 Dermatomyositis |
| D81.0 SCID with reticular dysgenesis | D83.8 Other Common Variable Immunodeficiency D83.9 | Other ICD-Code: _____ |
| D81.2 SCID with low or normal B cell numbers | Common Variable Immunodeficiency, unspecified | Prior failed medications: _____ |
| D81.5 Purine nucleoside phosphorylase deficiency | G11.3 Cerebellar ataxia with defective DNA | |
| D81.6 Major histocompatibility complex class I | | |
| D81.7 Major histocompatibility complex class II | | |

4: Pre-medications/Adverse Reaction Medications

Medication	Route	Dose/Strength	Sig (Please specify)	Qty.	Refills
Acetaminophen	PO	325 mg _____ 625 mg _____	PRN for fever, chills, and headache: take _____ tablet(s) Other: _____		
Cetirizine	PO	10 mg _____	PRN mild/mod allergic reaction: take _____ tablet(s) Other: _____		
Diphenhydramine	PO IV	25 mg _____ 50 mg _____	PRN mild/mod allergic reaction: take _____ tablet(s) Premed to be given 30 minutes prior to the infusion: take _____ tablet(s) Other: _____		
Epinephrine	IM	0.15 mg/0.3 mL _____ 0.3 mg/0.3 mL _____	For adults weighing > or = 30kg: administer a single dose, may repeat one time For adults weighing < 30kg: administer a single dose, may repeat one time		
Fexofenadine	PO	180 mg _____	PRN mild/mod allergic reaction: take _____ tablet(s) Other: _____		
Lidocaine	TOP	1.8% _____ 5% _____	Apply to injection sites at least 1 hour before Other: _____		
Methylprednisolone	IV	40 mg/mL _____ 80 mg/mL _____	PRN for mild/mod allergic reaction: Inject 125 mg slow IV push over 5 minutes Inject _____ mg slow IV push over _____ minutes		
Ondansetron	ODT IV	4 mg _____ 2 mg/mL _____ 8 mg _____	PRN for nausea and vomiting: take _____ tablet(s) Inject _____ mg slow IV push over _____ minutes		
Other: _____					

Intravenous Immune Globulin (IVIG) Referral Form

3233 Corporate Ct.
Ellicott City, MD 21043



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.

5. Administration assistance/ Patient Support and Injection Training Authorization

Assistance required No, assistance needed

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, 21044.

6: Prescription Information |

Medication	Route	Dose/Strength	Sig (Please include cycle)	Qty.	Refills
ANAVIP	IV		Infuse _____ vial(s) every _____ hours for _____ hours		
Atgam	IV	5 mg/mL	Infuse _____ mg per kg every _____ days Other: _____		
CroFab	IV		Infuse _____ vial(s) every _____ hours for _____ hours		
CytoGam	IV	2500 mg IgG	Initial: _____ mg/kg/hr for _____ mins, _____ mg/kg/hr for _____ mins, then _____ mg/kg/hr for _____ mins to complete; Subsequent: _____ mg/kg/hr for _____ mins, _____ mg/kg/hr for _____ mins, then _____ mg/kg/hr for _____ mins to complete		
DigiFab	IV	40 mg	Infuse _____ vial(s) every _____ hours for _____ hours		
Flebogamma DIF	IV	5% (50 mg/mL) 10% (100 mg/mL)	Infuse _____ grams per kg every _____ weeks (inf. rate: initial _____ MD: _____) Other: _____		
Gammagard Liquid	IV SQ	10% (100 mg/mL)	Infuse _____ grams per kg every _____ weeks (inf. rate: initial _____ MD: _____) Other: _____		
Gammaked	IV SQ	10% (100 mg/mL)	Infuse _____ grams per kg every _____ weeks (inf. rate: initial _____ MD: _____) Other: _____		
GamaSTAN S/D	IM		Administer a dose of _____ mL per kg; repeat every _____ months (if required) Other: _____		
Gamunex-C	IV SQ	10% (100 mg/mL)	Infuse _____ grams per kg every _____ weeks (inf. rate: initial _____ MD: _____) Other: _____		
HepaGamB	IV IM	1 mL 5 mL	Administer a dose of _____ mL per kg or _____ mL every _____ day or _____ week from Day _____ to _____; _____		
Hizentra	SQ	20% (0.2 g/mL)	Infuse _____ grams per kg _____ times every _____ weeks or _____ days Other: _____		
KEDRAB	IM	300 IU/ 2mL 1,500 IU/ 10mL	Administer a dose of _____ IU per kg Other: _____		
Nabi-HB	IM	1 mL 5 mL	Administer a dose of _____ mL Other: _____		
Privigen	IV	10% (0.1 g/mL)	Infuse _____ grams per kg every _____ weeks (inf. rate: initial _____ MD: _____) Other: _____		
Rhophylac	IV IM	1,500 IU (300mcg) /2mL pre-filled	Inject _____ IU/kg or _____ IU (inf. rate: _____ mL per _____ seconds) Other: _____		
Thymoglobulin	IV	25 mg/10mL	Infuse _____ mg/kg daily for _____ days Other: _____		
Varizig	IM	≥125 IU	Based on patient's weight _____ kg: Administer a single dose of _____ IU or _____ mL		
WinRho SDF Liquid	IV IM	600 IU 5,000 UI 1,500 IU 15,000 UI 2,500 IU	Inject _____ IU/kg or _____ mcg/kg (inf. rate: _____) Other: _____		
Other:					

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: _____