AccessLink
a BioScript Solutions system

Tel: 1-888-398-0028 | Fax: 1-855-278-5182

AccessLink Litfulo Prescription Form

Patient Information

Name: _____ **DOB** (DD/MM/YYYY): ____/_____/_____

Address: _____ **Allergies:** _____

Home #: _____ **Cell #:** _____ **Email:** _____

Patient to be initially contacted via: ☐ call ☐ email **Best time to reach patient:** ☐ morning ☐ afternoon ☐ evening

☐ Patient has consented to AccessLink receiving and using the information on this form and AccessLink contacting the patient

☐ Verbal Consent Received by: _____ Date of consent: _____

Prescription

☐ Litfulo 50mg orally once daily ☐ Other Instructions: _____

Quantity: _____ Refills: _____

Medical Clearance

Tuberclerosis Testing

☐ Completed Date: _____

Result: _____

☐ Required ☐ Not Required

AccessLink Services

☐ AccessLink to coordinate medical clearance for TB testing

☐ AccessLink to coordinate medical clearance for Shingrix vaccination

Medical Clearance

☐ Patient is medically cleared to initiate Litfulo therapy

OR

☐ Litfulo therapy can start after negative TB test

☐ Litfulo therapy can be started __ weeks after the ___ dose of Shingrix

Other Comments or Instructions:

Prescriber Info and Authorization

Clinic Contact: _____ **Address:** _____

Phone: _____ **Fax:** _____ **Email:** _____

Pharmacy to dispense: _____

Prescriber Name: _____ **License#:** _____

Prescriber Signature: _____ **Date:** _____

Prescriber Certification.
This prescription represents the original of the prescription drug order.
The pharmacy address noted above is the only intended recipient and there are no others.
The original prescription has been invalidated and securely filed, and it will not be transmitted elsewhere at another time.