This referral form is provided to help with patient safety. Prescribers are reminded patients may choose any pharmacy of their choice.

Avella Specialty Pharmacy

Alternate Prescription Referral Form

Distribution Locations

○ **Western Region Facility (AK, CA, ID, MT, OR, WA)**
Avella of Sacramento
Ph. 888.792.3888
Fax 888.554.3299

○ **Texas**
Avella of Austin
Ph. 877.470.7608
Fax 877.480.1746

○ **Florida**
Avella of Orlando
Ph. 877.296.3177
Fax 877.296.3179

○ **Natl. Distribution Ctr. (All others)**
Avella of Deer Valley
Ph. 877.546.5779
Fax 877.546.5780

avella.com
If you need a medication not listed, please contact us.

Local Pharmacies

○ 17612 N. 59th Ave.
Glendale, AZ 85308
Ph. 602.942.8270
Fax 602.942.2975

○ 5040 N. 15th Ave., #102
Phoenix, AZ 85015
Ph. 602.277.3181
Fax 602.277.3148

○ 1144 E. McDowell Rd. #402
Phoenix, AZ 85006
Ph. 602.257.1133
Fax 602.257.1134

○ 7336 East Deer Valley Road,
Suite 100, Scottsdale, AZ 85255
Ph. 480.538.0699
Fax 480.538.0795

○ 9777 N. 91st., #C-102
Scottsdale, AZ 85258
Ph. 480.451.3771
Fax 480.451.3503

○ 2155 E. Conference Dr., #101
Tempe, AZ 85284
Ph. 480.775.4784
Fax 480.730.9734

○ 2450 E. Guadalupe Rd., #110
Gilbert, AZ 85234
Ph. 480.633.6934
Fax 480.633.6974

○ 4512 E. Camp Lowell Dr.
Tucson, AZ 85712
Ph. 520.918.0044
Fax 520.918.0043

○ 701 Shadow Ln., Ste. 110
Las Vegas, NV 89106
Ph. 702.522.6483
Fax 702.479.1372

○ 1245 E. Colfax Ave. #102
Denver, CO 80218
Ph. 303.863.7644
Fax 303.863.7656

○ 4830 Knightsbridge Blvd, Ste. C
Columbus, OH 43214
Ph. 614.360.2800
Fax 614.360.2801

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:** ( ) _____ - _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

☐ _____ ☐ _____ **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*

Diagnosis: _____ **ICD-9:** _____

4: Prescription Information

Medication	Dose/Strength	Max. Daily Dosage	Sig	Qty.	Refills
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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: _____

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