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

Avella Specialty Pharmacy

HIV / AIDS 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.

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

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

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

◯ 10050 Banburry Cross Dr. #110
Las Vegas, NV 89144
Ph. 702.562.2294
Fax 702.562.2296

◯ 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

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

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

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:** _____ **Serum Creatinine:** _____

CD4 Count: _____ **Viral Load:** _____ **Date of labs:** _____

4: Prescription Information

Atripla® 600/300/200mg tabs Dispense 30 tabs Take 1 tab daily on empty stomach Refill X ____	Combivir® 150mg/300mg tabs Dispense 60 tabs Take 1 tab 2X daily Refill X ____	Complera® 200mg/25mg/300mg Dispense 1 month supply Take 1 tab once daily w/ meal Refill X ____	Egrifta® requires specific referral form. Please use Serono Egrifta Statement of Medical Necessity form.	Emtriva® 200mg caps Dispense 30 capsules Take 1 cap once daily Refill X ____
Edurant® 25mg tabs Dispense 30 tabs Take 1 tab daily with meal Refill X ____	Epivir® ____ mg tabs Dispense 1 month supply Take 1 tab ____ X daily Refill X ____	Epzicom® 600mg/300mg tabs Dispense 1 month supply Take one tablet daily Refill X ____	Fuzeon® 90mg Inj Dispense 1 kit Inject 90mg under skin 2x daily Refill X ____	Intelence® ____ mg tabs Dispense 1 month supply Take ____ tabs ____ X daily Refill X ____
Isentress® 400mg tabs Dispense 60 tabs Take 1 tab 2X daily Refill X ____	Kaletra® 200/50mg tabs Dispense 120 tabs Take ____ tabs ____ X daily Refill X ____	Lexiva® 700mg tabs Dispense 1 month supply Take ____ tabs ____ X daily Refill X ____	Mepron® 750mg/5ml ☐ sachet ☐ suspension Dispense ____ day supply Take ____ ml ____ X daily Refill X ____	Norvir® 100mg tabs Dispense 1 month supply Take ____ tabs ____ X daily Refill X ____
Prezista® ____ mg tabs Dispense 1 month supply Take ____ tabs ____ X daily Refill X ____	Rescriptor® 200mg tabs Dispense 180 tabs Take 2 tabs 3X daily Refill X ____	Retrovir® ____ mg tabs Dispense 1 month supply Take ____ tabs ____ X daily Refill X ____	Reyataz® ____ mg caps Dispense 1 month supply Take ____ caps ____ X daily Refill X ____	Selzentry® ____ mg tabs Dispense 1 month supply Take ____ tabs ____ X daily Refill X ____
Serostim® ____ mg Inject ____ mg SC daily Refill X ____	Stribild™ tablets Take 1 tablet daily Refill X ____	Sustiva® 600mg tablets Dispense 30 tablets Take 1 tab at bedtime Refill X ____	Trizivir® 300/150/300mg tabs Dispense 60 tabs Take 1 tab 2X daily Refill X ____	Truvada® 200mg/300mg tabs Dispense 30 tabs Take 1 tab once daily Refill X ____
Viramune® ____ mg tabs Dispense ____ Take ____ tab ____ X daily Refill X ____	Viread® 300mg tabs Dispense ____ tablets Take ____ daily Refill X ____	Ziagen® 300mg tabs Dispense 60 tabs Take ____ tab ____ X daily Refill X ____	Zithromax® 600mg tabs Take ____ tabs ____ X daily Take ____ tabs ____ X weekly Refill X ____	Other: ☐ Refill X ____

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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