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

Avella Specialty Pharmacy | Rheumatoid Arthritis 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.

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 Info:** _____

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

Diagnosis: ☐ **Other:** _____

Prior failed medications (medication and duration of treatment/reason for d/c):

☐ _____

☐ _____

Is patient currently on RA therapy? ○ Yes ○ No

Medications: _____

Xeljanz NOT to be used in combination with biologic DMARD's

TB/PPD test given? ○ Yes ○ No

BMD/T-score: _____ **Date:** _____

Does patient have a latex allergy? ○ Yes ○ No

Is Patient at risk for osteoporotic fracture as evident by any of the following?

☐ History of osteoporotic fracture Site: _____ Date: _____

☐ Patient has tried and failed an oral bisphosphonate

☐ Patient has documented contraindication/is intolerant to oral bisphosphonate therapy (please submit a copy of DEXA w/prescription)

4: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Humira®**	☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled Syringe	☐ Inject 40mg SC every OTHER week ☐ Inject 40mg SC ONCE a week	4-week supply	
☐ **Enbrel®**	☐ 50mg/ml SureClick™ Autoinjector ☐ 50mg/ml Prefilled Syringe ☐ 25mg Prefilled Syringe	☐ Inject 50mg SC ONCE a week ☐ Inject 25mg TWICE a week, 72 to 96 hours apart ☐ **Other:**	4-week supply	
☐ **Cimzia®** Initial Dose	200mg Starter Kit (contains 6, 200mg PFS) (NDC 50474-0710-81)	Inject 400mg SC once, then repeat at weeks 2 and 4	4-week supply	No refills
☐ **Cimzia®** Maintenance Treatment	2 x 200mg Prefilled Syringe (NDC 50474-0710-9)	☐ 200mg SC ONCE every TWO weeks ☐ 400mg SC ONCE every FOUR weeks	4-week supply	
☐ **Forteo®** ☐ **Pen Needles**	☐ 750ug/3ml Pen 31 gauge 6mm	☐ Inject 20ug SC as directed ONCE a day	4-week supply 28 needles	
☐ **Orencia®**	☐ 125mg/ml Prefilled Syringe (4 syringes)	☐ Inject 125mg SC ONCE weekly	☐ Vials	
☐ **Simponi®**	☐ 50mg/0.5ml Prefilled Syringe ☐ 50mg/0.5ml Autoinjector	☐ Inject 50mg ONCE a month	4-week supply	
☐ **Prolia®**	☐ 60mg Prefilled Syringe			
☐ **Synvisc®**				
☐ **Supartz®**	☐ 25mg	☐ Inject 25 mg per 2.5 mL INTRA-ARTICULARLY into the knee once weekly for a total of 5 injections		
☐ **Xeljanz®**	☐ 5mg	☐ Take 5mg TWICE daily		
☐				

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: _____

OUPrqKjO