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

Avella Specialty Pharmacy | Urology 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

◯ **Natl. Distribution Ctr**
Avella of Deer Valley
Ph. 877.546.5779
Fax 877.546.5780

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

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:** _____ **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:** _____

Renal Dysfunction: ◯ Yes ◯ No **Liver Dysfunction:** ◯ Yes ◯ No **H/H (Hemoglobin/Hematocrit):** _____ _____

To expedite prior authorization services, please provide Chemo regimen/schedule, last clinical notes and/or lab values/scans:

Date and value of last HbA1c _____ **Date and value of last Serum PSA** _____

Date and value of last Serum Testosterone _____ **Date of Orchiectomy** _____ / _____ / _____

4: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Zytiga®**	☐ 250 mg	☐ Take 4 tablets daily without food		
☐ With Prednisone	☐ 5mg	☐ 5mg BID with food ☐ Other:		
☐ **Xgeva®**				
☐ **Xtandi®**				
☐ **Casodex®**				
☐ **Eligard®**				
☐ **Lupron®**				
☐ **Nilandron®**				
☐ **Zoladex®**				
☐				
☐				
☐				
☐				

Call Avella for compounded medications: **(877) 470-7597 ext 3784**

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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