Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Avella Specialty Pharmacy | Rheumatology Prescription Referral Form

Send your Rx to: | Choose Location

avella.com
If you have questions or concerns, 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

Provider Name: _____ **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:

☐ **Other:** _____

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

☐ _____

Is patient currently on RA therapy? ○ Yes ○ No

Medications: _____

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

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Benlysta**	☐ 200mg/ml autoinjector ☐ 200mg/ml PFS	☐ Inject 200mg SC once weekly in the abdomen or thigh **If transitioning from IV therapy with Benlysta to SC administration, administer the first SC dose 1 to 4 weeks after the last IV dose*	4-week supply	
☐ **Enbrel**	☐ 50mg/ml SureClick™ Autoinjector ☐ 50mg/ml Prefilled Syringe ☐ 25mg/0.5ml Prefilled Syringe	☐ Inject 50mg SC ONCE a week ☐ Inject 25mg TWICE a week, 72 to 96 hours apart ☐ **Other:**	4-week supply	
☐ **Forteo**	☐ 600mcg/2.4ml PFS	☐ Inject 20mcg SC, as directed, once daily	4-week supply	
☐ **Humira** ☐ Injection training from My Humira *(patient must sign below)*	☐ 20mg Pen ☐ 20mg PFS ☐ 40mg Pen CF ☐ 40mg Pen ☐ 40mg PFS CF ☐ 40mg PFS ☐ 80mg Pen CF ☐ 80mg Pen ☐ 80mg PFS CF ☐ 80mg PFS ☐ Starter Pack	☐ Inject 40mg SC every OTHER week ☐ Inject 40mg SC ONCE a week	4-week supply	
☐ **Kevzara**	☐ 150mg/1.14ml PFS ☐ 200mg/1.14ml PFS	☐ Inject 200mg SC once every 2 weeks ☐ **Other:**	4-week supply	
☐ **Olumiant**	☐ 2mg Tablet	☐ 2 mg orally once daily as monotherapy or in combination with methotrexate or other disease-modifying antirheumatic drugs	30	
☐ **Otezla**	*Please use Otezla-specific referral form available at **avella.com/forms***			
☐ **Pen Needles**	31 gauge 6mm		28 needles	
☐ **Prolia**	☐ 60mg Prefilled Syringe	☐ Inject 60mg SC ONCE every 6 months		
☐ **Rinvoq**	☐ 15mg ER tablets	☐ Monotherapy: 15mg once daily with or without food	30	
☐ **Simponi**	☐ 50mg/0.5ml Prefilled Syringe ☐ 50mg/0.5ml Autoinjector	☐ Inject 50mg ONCE a month	4-week supply	
☐ **Tymlos**	☐ 3120mcg/1.56ml	☐ 80 mcg SC once daily into periumbilical region; give with supplemental calcium and vitamin D if dietary intake is not adequate	1 pre-filled pen	

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 _____

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