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 | Bevacizumab Referral Form

avella.com

○ National Distribution Center
Avella of Deer Valley

Ph.: 877.470.7597
Fax: 877.480.1748

Date Medication Needed: ___ ___ _____

1: Prescriber Information

Clinic name: _____ Prescriber Name: _____ NPI#: _____

Address: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: (_____) _____ - _____

2: Patient Information

Patient Name: _____ Birthdate: _____ _____ _____ Preferred Phone: (____) ____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Known Allergies: _____ Diagnosis Code: _____

3: Product Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ Bevacizumab	☐ 1.25mg / 0.05mL ☐ 1.00mg / 0.04mL ☐ 2.5mg / 0.1mL	Inject contents of syringe intravitreally (Medication to be administered by provider in office only).		

For other medication orders please use Avella Ophthalmology Referral form.

Notes:

Prescriber Signature: Prescriber, please sign and date below

Dispense as written | Date | Substitution Permissable | Date

# of Prescriptions: _____

Avella Internal Use Only:

Order verified with (enter prescriber staff name): _____

Pharmacist Initials: _____ **Office HBS #:** _____

Notes:

Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.