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 | Prescription Referral Form

◯ **East Regional Distribution Center:**
Avella of Orlando
Ph. 877.296.3177
Fax 877.296.3179

◯ **West Regional Distribution Center.**
Avella of Deer Valley
Ph. 877.546.5779
Fax 877.546.5780

Distribution Locations

For additional forms, please contact your Account Manager or visit **www.avella.com/forms**

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

Provider Name(s):

☐ _____ **DEA#:** _____ **NPI#:** _____
☐ _____ **DEA#:** _____ **NPI#:** _____
☐ _____ **DEA#:** _____ **NPI#:** _____
☐ _____ **DEA#:** _____ **NPI#:** _____
☐ _____ **DEA#:** _____ **NPI#:** _____
☐ _____ **DEA#:** _____ **NPI#:** _____
☐ _____ **DEA#:** _____ **NPI#:** _____
☐ _____ **DEA#:** _____ **NPI#:** _____
☐ _____ **DEA#:** _____ **NPI#:** _____
☐ _____ **DEA#:** _____ **NPI#:** _____

Practice Info:

Practice Name: _____
Address: _____
City, State: _____
Zip: _____ **Tax ID#:** _____
Phone: _____ **Fax:** _____
Key Contact: _____
Key Contact Phone: _____
Key Contact Email: _____

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

Diagnosis: _____ **ICD-10:** _____

4: Prescription Information

Medication	Dose/Strength	Max. Daily Dosage	Sig	Qty.	Refills
☐					
☐					
☐					
☐					
☐					
☐					
☐					

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: _____