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.

Patient Referral Form

Send your Rx to: | **Avella of Deer Valley** | **24416 N. 19th Ave. Phoenix, AZ 85085** | **Ph.: 877-546-5779 Fax: 877-546-5780** | **avella.com** If you have questions or concerns, please contact us.

Date Medication Needed: ____________ **Ship To:** Patient's Home   Prescriber's Office   New Start   Continuing/Restart Treatment

1: Patient Information

Afrezza Patient Name: ____________ **Sex:** Male Female **Height:** ______ **Weight:** ______ lbs. kg.

Birthdate: ____________ **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*

Diabetes Mellitus   Type 1   Type 2   HbA1c ≥ 7%   Yes   No

Has patient been a non-smoker for at least 6 months? Yes No

Does patient have chronic lung disease, such as asthma or COPD? Yes No

Has patient completed a baseline FEV_1 test? Yes No

Has patient received or is receiving AFREZZA®? Yes No

Is adult patient receiving basal insulin via an insulin pump? Yes No

If yes, what is the insulin product being used? ____________

Is adult patient being prescribed AFREZZA® for Type 1 diabetes mellitus in combination with a long-acting basal insulin? Yes No

Has patient experienced an inadequate treatment response, contraindication, or intolerance or tolerance to OAD (oral antidiabetic) medication? Yes No

Is patient non-compliant with injected rapid-acting insulin therapy due to inability or unwillingness to inject or intensify therapy? Yes No

Has patient used rapid-acting insulin therapy within the last 3 months without achieving goal OR with unacceptable postprandial hypoglycemia? Yes No

Additional supporting documentation attached: Lab Results   Treatment History FEV_1 Other Clinical Information: ____________

4: Prescription Information

Dispense AFREZZA® (insulin human) Inhalation Powder as follows:

Quantity	Description	NDC
180 Cartridges	90 – 4-unit cartridges and 90 – 8-unit cartridges and 2 inhalers (Titration Pack)	NDC 47918-880-18
180 Cartridges	60 – 4 unit cartridges, 60 – 8 unit cartridges, 60 – 12 unit cartridges and 2 inhalers (Titration Pack)	NDC 47918-902-18
90 Cartridges	90 – 4-unit cartridges and 2 inhalers	NDC 47918-874-90
90 Cartridges	90 – 8-unit cartridges and 2 inhalers	NDC 47918-878-90
90 Cartridges	90 – 12-unit cartridges and 2 inhalers	NDC 47918-891-90

Additional Prescribing Info: ____________

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: ______