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 | Celgene® Prescription Referral Form

Distribution Location

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

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

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):

☐ _____ **NPI#:** _____

☐ _____ **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

*To expedite prior authorization services, **please FAX** current and past Chemo regimen(s)/schedule, last clinical notes and/or lab values/scans*

Diagnosis: _____

ICD-10: *(required for Medicare B billing)* _____ **BSA** _____ m^2

Renal Dysfunction: ○ Yes ○ No

Current SCr _____ **or current GFR** _____ **ml/min**

Liver Dysfunction: ○ Yes ○ No

Abnormal Lab Value(s) _____

H/H (Hemoglobin/Hematocrit): _____ _____

Other: _____

_____

4: Prescription Information

☐ **Pomalyst®** (pomalidomide)

☐ **Revlimid®** (lenalidomide)

☐ **Thalomid®** (thalidomide)

Please circle one:

Adult Female - NOT of reproductive potential | *Adult Female - of reproductive potential* | *Male Child*

Female Child - NOT of reproductive potential | *Female Child - of reproductive potential* | *Adult Male*

STRENGTH/DIRECTIONS (SIG):

Provider Authorization #: _____ **Date:** _____

Quantity: _____

☐ **Dexamethasone®** (dexamethasone)

STRENGTH/DIRECTIONS (SIG):

Provider Authorization #: _____ **Date:** _____

Quantity: _____

Prescriber Signature: Prescriber, please sign and date below

Dispense as written | Date | Substitution Permissible | Date

I authorize Avella Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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: _____