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 | Imbruvica® 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 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):

☐ _____ **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): _____ _____
Confirmed Mutations: ☐ EGFR ☐ ALK ☐ BRAF V600E ☐ BRAF V600K
☐ CLL with 17p deletion ☐ Other: _____

4: Prescription Information

The patient identified below has requested a refill for Imbruvica. Due to recent changes in formulation we are requesting a new prescription for Imbruvica tablets. The tablets come in 560mg, 420mg, 280mg, 140mg strengths and there is also a 70mg capsule available.

Patient Name: _____ **Birthdate:** _____ **Prescriber:** _____
Address: _____ **Prescriber Fax:** _____
City: _____ **State:** _____ **ZIP:** _____

Previous Imbruvica directions:

Imbruvica 140mg Capsules

☐ Take 1 capsule by mouth once daily = 140mg
☐ Take 2 capsules by mouth once daily = 280mg
☐ Take 3 capsules by mouth once daily = 420mg
☐ Take 4 capsules by mouth once daily = 560mg
☐ Other: _____

New Prescription for Imbruvica Tablets for the above listed patient

Product

☐ Imbruvica 140 mg tablet
☐ Imbruvica 280mg tablet
☐ Imbruvica 420mg tablet
☐ Imbruvica 560mg tablet
☐ Imbruvica 70mg capsules

Directions

☐ Take one tablet by mouth once daily
☐ Other: _____

Refills

☐ _____
☐ Other: _____

Qty

☐ 28 tablets / capsules
☐ Other: _____

MD Signature _____ **Date:** _____

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: _____

QBzb77B8