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 | Oncology Prescription Referral Form

Send your Rx to:

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

SOLID TUMORS

- ☐ Afinitor (everolimus)
- ☐ Afinitor Disperz (everolimus)
- ☐ Alecensa (alectinib)
- ☐ Braftovi (encorafenib)
- ☐ Cabometyx (cabozantinib)
- ☐ Erivedge (vismodegib)
- ☐ Femara (letrozole)
- ☐ Hycamtin (topotecan)
- ☐ Inlyta (axitinib)
- ☐ Iressa (gefitinib)
- ☐ Lorbrena (lorlatinib)
- ☐ Mekinist (trametinib)
- ☐ Mektovi (binimetinib)
- ☐ Nexavar (sorafenib)
- ☐ Nolvadex (tamoxifen)
- ☐ Nubeqa (darolutamide)
- ☐ Odomzo (sonidegib)
- ☐ Piqray (alpelisib)
- ☐ Rozlytrek (entrectinib)
- ☐ Rubraca (rucaparib)
- ☐ Stivarga (regorafenib)
- ☐ Sutent (sunitinib)
- ☐ Tafinlar (dabrafenib)
- ☐ Tagrisso (osimertinib)
- ☐ Talzenna (erlotinib)
- ☐ Tarceva (erlotinib)
- ☐ Temodar (temozolomide)
- ☐ Tykerb (lapatinib)
- ☐ Verzenio (abemaciclib)
- ☐ Vizimpro (dacomitinib)
- ☐ Votrient (pazopanib)
- ☐ Xalkori (crizotinib)
- ☐ Xeloda (capecitabine
- ☐ Xtandi (enzalutamide)
- ☐ Zykadia (ceritinib)
- ☐ Zolinza (vorinostat)
- ☐ _____

LIQUID TUMORS

- ☐ Bosulif (bosutinib)
- ☐ Calquence (acalabrutinib)
- ☐ Copiktra (duvelisib)
- ☐ Exjade (deferasirox)
- ☐ Gleevec (imatinib)
- ☐ Inrebic (fedratinib)
- ☐ Jadenu (deferasirox)
- ☐ Jakafi (ruxolitinib)
- ☐ Rydapt (midostaurin)
- ☐ Sprycel (dasatinib)
- ☐ Tasigna (nilotinib)
- ☐ Zydelig (idelalisib)
- ☐ _____

STRENGTH/DIRECTIONS (SIG): _____ Qty: _____ Refills: _____

☐ **Kisqali** (ribociclib) 600 mg orally once daily for 21 days, then 7 days off Qty: _____ Refills: _____

☐ **w/ Letrozole** 2.5 mg orally once daily (or another aromatase inhibitor) throughout the 28-day cycle Qty: _____ Refills: _____

☐ **Erleada™** Give 4 tablets (240 mg) by mouth daily Qty: _____ Refills: _____

Give with a gonadotropin-releasing hormone (GnRH) analog if the patient has not had a bilateral orchiectomy

☐ **Pomalyst** (pomalidomide) ☐ **Thalomid** (thalidomide) ☐ **Revlimid** (lenalidomide) ☐ **Dexamethasone** (dexamethasone)

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: _____ Qty: _____ Refills: _____

SUPPORTIVE MEDICATIONS

- ☐ Aranesp (darbepoetin alfa)
- ☐ Arixtra (fondaparinux)
- ☐ Emend (aprepitant)
- ☐ Granix (tbo-filgrastim)
- ☐ Lovenox (enoxaparin)
- ☐ Neulasta (pegfilgrastim)
- ☐ Neupogen (filgrastim)
- ☐ Nplate (romiplostim)
- ☐ Procrit (epoetin alfa)
- ☐ Promacta (eltrombopag)
- ☐ Sancuso (granisetron)
- ☐ Xgeva (denosumab)
- ☐ Zarxio (filgrastim-sndz)
- ☐ Zofran (ondansetron)
- ☐ _____

STRENGTH/DIRECTIONS (SIG): Qty: _____ Refills: _____

☐ **Imbruvica** (ibrutinib) Sig: _____ Qty: _____ Refills: _____

WM 420mg, CLL 420mg, cGVHD 420mg, SLL 420mg; MCL 560mg, MZL 560mg all dosed once daily

☐ **Lonsurf** (tipiracil/trifluridine) ☐ 15 mg/6.14 mg Qty: _____ Refills: _____ ☐ 20 mg/8.19 mg Qty: _____ Refills: _____

Take _____ mg (35mg/m2 based on trifluridine component) twice daily within 1 hour of completion of morning and evening meals on days 1 through 5 and days 8 through 12 of each 28-day cycle. (round dose to nearest 5mg, max of 80mg/dose)

☐ **Cotellic** (cobimetinib) Three tablets (60mg) for 21-days on and 7-days off, then repeat.

☐ **Zelboraf** (vemurafenib) Four tablets (960mg) every 12 hours Qty: 240 tablets Refills: _____

☐ **Zytiga** (abiraterone) 250 mg 4 QD Qty: _____ Refills: _____

☐ **w/ Prednisone** 5 mg BID w/ food Qty: _____ Refills: _____

☐ **Ibrance** (palbociclib) _____ mg QD w/ food for 21 days, then 7 days off. Qty: 21 caps

☐ **w/ Letrozole** 1 tablet (2.5 mg) QD. Qty: 28 tablets Refills: _____

☐ **Ninlaro** (ixazomib) One _____ mg capsule once weekly on days 1, 8, and 15 of a 28-day cycle, 1 hour before or 2 hours after food. Qty: 3 capsules Refills: _____

Revlimid One _____ mg capsule for 21 days, then 7-days off, then repeat cycle. Qty: 21 capsules Prov. Auth.# _____

Dexamethasone 40mg (10 tablets) once weekly on days 1,8,15, and 22 of a 28-day cycle. Qty: 40 tablets Refills: _____

☐ **Venclexta** (venetoclax) ☐ Starter Pack Ramp-up dosing: Week 1: 20mg po QD; Week 2: 50mg po QD; Week 3: 100mg po QD; Week 4: 200mg po QD

Sig: _____

☐ Maintenance: 400mg po qd after completion of ramp-up dosing

Sig: _____

☐ 10mg ☐ Wallet ☐ Unit dose
☐ 50mg ☐ Wallet ☐ Unit dose
☐ 100mg ☐ 120 Bottle ☐ Unit dose Qty: _____ Refills: _____

☐ **Allopurinol** Strength: _____ Qty: _____ Refills: _____

Sig: _____

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.

# of Prescriptions: _____