☐ **Avella Natl. Distribution**
Ph.: (877) 546-5779
Fax: (877) 546-5780

☐ **Avella of Sacramento**
Ph.: (888) 792-3888
Fax: (888) 554-3299

☐ **Avella of Austin**
Ph.: (877) 470-7608
Fax: (877) 480-1746

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.

EXJADE® is indicated for the treatment of chronic iron overload due to blood transfusions (transfusional hemosiderosis) in patients 2 years and older. In these patients, EXJADE has been shown to reduce liver iron concentration and serum ferritin levels. Clinical trials to demonstrate increased survival or to confirm clinical benefit have not been completed.

Individualize the decision to initiate EXJADE therapy based on consideration of the anticipated clinical benefit and risks of the therapy, taking into consideration factors such as the life expectancy and comorbidities of the patient.

The safety and efficacy of EXJADE when administered with other iron chelation therapy have not been established.

Further studies are being performed to determine the long-term benefits and risks of EXJADE.

IMPORTANT SAFETY INFORMATION

WARNING: RENAL, HEPATIC FAILURE AND/OR GASTROINTESTINAL HEMORRHAGE

EXJADE may cause:

- **renal impairment, including failure**
- **hepatic impairment, including failure**
- **gastrointestinal hemorrhage**

In some reported cases, these reactions were fatal. These reactions were more frequently observed in patients with advanced age, high risk myelodysplastic syndromes (MDS), underlying renal or hepatic impairment or low platelet counts (<50 x 10^9/L). EXJADE therapy requires close patient monitoring, including measurement of:

- **serum creatinine and/or creatinine clearance prior to initiation of therapy and monthly thereafter; in patients with underlying renal impairment or risk factors for renal impairment, monitor creatinine and/or creatinine clearance weekly for the first month, then monthly thereafter;**
- **serum transaminases and bilirubin prior to initiation of therapy, every two weeks during the first month and monthly thereafter.**

PRESCRIBER INFORMATION 1

Prescriber Name: ____________________

Specialty: ____________________

State License #: __________ DEA #: ____________________

National Prescriber Identification (NPI) #: ____________________

Phone: ____________________ Fax: ____________________

Address: ____________________

City: ____________________ State: ________ ZIP: __________

Office Contact Name: ____________________

PRESCRIBER INFORMATION 2

Drug: EXJADE® (deferasirox) # of Days Supplied: ____________________

# of Refills: ____________ Patient Weight (kg): ____________________

Total Daily Dose: ____________________ (must be divisible by 125 mg)

Frequency: ____________________

Other Prescribing Information: ____________________

Date ____________________

____________________ ____________________
Dispense as Written **Substitution Permissible**

Total Number of Prescriptions Written ____________

CLINICAL INFORMATION 3

EXJADE is contraindicated in patients with:

- creatinine clearance <40 mL/min or serum creatinine >2 times the age-appropriate upper limit of normal;
- poor performance status and high-risk myelodysplastic syndromes or advanced malignancies;
- platelet counts <50 x 10^9/L;
- known hypersensitivity to deferasirox or to any component of EXJADE.

Prior or current Desferal®/deferoxamine patient? ☐ YES ☐ NO

Check one:
Transfusion History:
☐ <10 units ☐ 10-20 units ☐ >20 units

Transfusions per month: ____________

Serum Ferritin Level (within 1 to 4 weeks): ____________

Primary Diagnosis: ____________________ ICD-10: __________

Reason for EXJADE® therapy: ____________________ ICD-10: __________

PATIENT INFORMATION 4

Patient Name: ____________________ DOB: ____________

Gender: ☐ M ☐ F Language Preference: ____________________

Race (optional) ☐ African American ☐ Caucasian ☐ Hispanic ☐ Asian ☐ Other

Phone: ____________________ Work Phone: ____________________

Cell Phone: ____________________ Emergency Contact: ____________________

Address: ____________________

City: ____________________ State: ________ ZIP: __________

Email Address: ____________________

Best Time to Call: ☐ AM ☐ PM

PATIENT INFORMATION 5

Do you have prescription coverage? ☐ YES ☐ NO

If no, you will be contacted to discuss alternate coverage.

If yes, either **submit an enlarged photocopy of the front and back of your Rx card** or complete the following section.

Prescription Insurer Name: ____________________

Rx Bin #: ____________________ Rx PCN # (if applicable): ____________________

Rx Group #: ____________________

ID #: ____________________

Name on Card: ____________________

Pharmacy Services Phone # (back of card): ____________________

Medical/Secondary Insurer: ____________________

Policy Holder's Name: ____________________

Phone: ____________________ MD's Provider #: ____________________

Group #: ____________________ Policy #: ____________________

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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.**