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 | Asthma / Allergy Enrollment 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 ○ Pick-up (store location): _____ 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: _____ **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*

Diagnosis/ICD-10: _____ **Patient Evaluation:** **Height:** _____ **in/cm** **Weight:** _____ **kg/lbs**
Allergies: _____

4: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **AUVI-Q®** (epinephrine injection, USP)	☐ 0.15 mg ☐ 0.3 mg	☐ Inject one injector into outer thigh IM for anaphylaxis. Press firmly and hold for 5 seconds. Call 911. OR ☐ Inject one injector into outer thigh IM for anaphylaxis. May repeat one time after _____ minutes. Call 911.	☐ **1** (one) Carton (2 (two) auto-injectors and 1 (one) Trainer) ☐ **2** (two) Cartons (4 (four) auto-injectors and 2 (two) Trainers)	
☐ **Cinqair®** (reslizumab)	☐ 10mg/1ml	3mg/kg IV infusion over 20 to 50 minutes every 4 weeks	**4-week supply**	☐ _____
☐ **Cromolyn**	☐ 20mg/2ml		**4-week supply**	☐ _____
☐ **EpiPen®** ☐ **EpiPen® Jr.**		☐ Inject one injector into outer thigh IM for anaphylaxis. Press firmly and hold for 5 seconds. Call 911. OR ☐ Inject one injector into outer thigh IM for anaphylaxis. May repeat one time after _____ minutes. Call 911.	1	
☐ **Fasenra™** (benralizumab)	☐ 30mg/1ml	Adults and Pediatrics (age 12 or greater): 30 mg subQ once every 4 weeks for the first 3 doses, and then once every 8 weeks; inject into the upper arm, thigh, or abdomen	☐ _____	☐ _____
☐ **Xolair®** (Omalizumab) ☐ *I certify that the rationale for Xolair therapy for Allergic Asthma is necessary for this patient and I will be supervising the patient's treatment accordingly.*	☐ 150mg vial kit	Every 4 weeks dosing: ☐ Administer 150mg per dose subcutaneously every 4 weeks ☐ Administer 300mg per dose subcutaneously every 4 weeks ☐ Other: Administer _____ mg per does subcutaneously every 4 weeks Every 2 weeks dosing: ☐ Administer 225mg per dose subcutaneously every 2 weeks ☐ Administer 300mg per dose subcutaneously every 2 weeks ☐ Administer 375mg per dose subcutaneously every 2 weeks ☐ Other: Administer _____ mg per does subcutaneously every 2 weeks ☐ Please supply one vial of sterile water (10ml per vial) for every vial of Xolair® dispensed and include ancillary supplies (syringe and needle, alcohol swabs). **Supplies:** • 1 vial sterile water for injection (10 mL vial) for ever vial of Xolair dispensed • NDL 25G x 5/8" Safety Glide needle for subcutaneous injection • Alcohol swabs • Flexible bandages 1" x 3" • 3 mL Luer Lock injection syringe • NDL 18G x 1 & ½" Safety Glide needle for reconstitution Send quantity sufficient for medication days supply. ☐ No supplies (The above supplies will be sent with shipment unless indicated).	☐ 30-day supply* ☐ 90-day supply* ☐ ____ month supply* * Maximum supply subject to health benefit limit	☐ 12 months ☐ _____
☐ **Nucala®** (mepolizumab)	☐ 100mg vial	Inject 100mg subcutaneously once every 4 weeks into the upper arm, thigh, or abdomen ☐ Please supply one vial of sterile water (10ml per vial) for every vial of Nucala dispensed and include ancillary supplies (syringe and needle, alcohol swabs). **Supplies:** • 1 sterile water for injection (10ml) for every vial of Nucala dispensed • 1-ml polyprophylene syringe with 21- to 27- G x 0.5-inch needle for subcutaneous injection • Alcohol swabs • 3 mL Luer Lock injection syringe • NDL 21G needle for reconstitution Send quantity sufficient for medication days supply. ☐ No supplies (The above supplies will be sent with shipment unless indicated).	☐ 30-day supply* ☐ 90-day supply* ☐ ____ month supply* * Maximum supply subject to health benefit limit	☐ 12 months ☐ _____
☐ **Other**				

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 _____

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: _____