ASSERTIO
PATIENT PRESCRIPTION ACCESS

Avella
Specialty Pharmacy

Patient Enrollment Form:

GRALISE® (gabapentin) tablets
CAMBIA® (diclofenac potassium for oral solution)
ZIPSOR® (diclofenac potassium) Liquid Filled Capsules

Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Cell Phone: (_____) _____
Date of Birth: ____/____/____ Sex: ☐ Male ☐ Female
ICD-10 or Diagnosis: _____
Tried/Failed Medication: _____

Physician Name: _____
State Lic # _____ DEA #: _____
NPI #: _____
Address: _____
City: _____ State: _____ Zip: _____
Physician Office Contact Name: _____
Physician Phone: (215) 957-9250
Physician Fax: (215) 957-9254

Please Provide: ☐ Patient Demographic Sheet ☐ Prescription/Pharmacy Benefit Information/Cards
Rx Plan Name: _____ Patient ID: _____ Rx Group: _____ Rx Bin #: _____ Rx PCN: _____

Assertio, Inc. Prescription Order Form

Check Box	Medication(s) Prescribed	Quantity	Refills	Reasons for Prescribing — Check all that apply
☐	**Gralise Tablets** Take by mouth daily with evening meal Sig: ☐ 600 mg ☐ 300 mg	Quantity Ordered ☐ 90 Other _____	☐ 6 ☐ 12 Other _____	☐ Requires Gralise to treat PHN pain ☐ Patient has tried and failed gabapentin IR or pregabalin ☐ Cannot reach effective dose of gabapentin IR ☐ Cannot take mid afternoon dose of TID gabapentin IR ☐ Other
☐	**Cambia 50 mg Oral Solution** Mix contents of 1 packet with 1- 2 oz of water. Drink immediately as a single dose.	Quantity Ordered ☐ 9 Other _____	☐ 6 ☐ 12 Other _____	☐ Requires Cambia for acute migraine attacks ☐ Patient tried and failed generic sumatriptan List prescription _____ ☐ Patient has difficulty swallowing tablets ☐ Patient has vomiting, gastric stasis ☐ Triptan medications not effective ☐ Tried and failed diclofenac tablets ☐ Other
☐	**Zipsor 25 mg Capsules** Take one 25 mg capsule by mouth Q.I.D. Add'l Instructions:	Quantity Ordered ☐ 120 Other _____	☐ 3 Other _____	☐ Requires Zipsor for mild to moderate acute pain ☐ Patient tried other NSAIDs without success ☐ Tried at least 2 generic prescription NSAIDS List prescription _____ List prescription _____ ☐ Other

I authorize Avella Pharmacy, their affiliates and representatives to act as an agent to initiate/execute the insurance prior authorization process.
I attest that this medication is being prescribed for the indication of the particular product.

Prescriber Signature: _____ Date: _____

UPON PATIENT APPROVAL, PLEASE FAX TO 888.901.3609

24416 N. 19th Avenue, Phoenix, AZ 85085 • Phone: 877.546.5779 • Fax: 888.901.3609

NCPDP# 0360987 • NPI# 1780030163

☐ Coverage Previously Attempted