

Need By Date: \_\_\_\_\_ Ship To: ☐ Patient ☐ Office ☐ Other \_\_\_\_\_ Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back

Patient Information		Prescriber Information	
Patient Name		Prescriber Name	
Address		Address	
City State ZIP		City State ZIP	
Main Phone	Alternate Phone	Phone	Fax
Social Security #		Contact Person	
Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	DEA #	NPI # License #

Clinical Information	
Diagnosis	ICD-10
Drug Allergies	Status: <input type="checkbox"/> New <input type="checkbox"/> Restart <input type="checkbox"/> Continuing

Please Attach Supporting Labs and Provide Medication List

Prescription Information	
Indicate Type From PPAF (check one): <input type="checkbox"/> Adult Female - Reproductive Potential (FRP) <input type="checkbox"/> Adult Female - NOT of Reproductive Potential (FNRP) <input type="checkbox"/> Adult Male <input type="checkbox"/> Female Child - Reproductive Potential (FRP) <input type="checkbox"/> Female Child - NOT of Reproductive Potential (FNRP) <input type="checkbox"/> Male Child	
Authorization # (to be filled in by healthcare provider; authorization # is only valid for 30 days; 7 days for FRP)	Date
Confirmation # (to be filled in by pharmacy)	Date

Med	Dose/Strength	Directions	Qty	Refills
<input type="checkbox"/> Pomalyst®	<input type="checkbox"/> 1 mg <input type="checkbox"/> 2 mg <input type="checkbox"/> 3 mg <input type="checkbox"/> 4 mg	<input type="checkbox"/> Take 1 cap PO daily, days 1-21 of 28 day cycle <input type="checkbox"/> _____	21 _____	No Refills No Refills
<input type="checkbox"/> Revlimid®	<input type="checkbox"/> 2.5 mg <input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 15 mg <input type="checkbox"/> 20 mg <input type="checkbox"/> 25 mg	<input type="checkbox"/> Take 1 cap PO daily <input type="checkbox"/> Take 1 cap PO daily, days 1-21 of 28 day cycle <input type="checkbox"/> _____	28 21 _____	No Refills No Refills No Refills
<input type="checkbox"/> Thalomid® Supplied in blister packs of 28 caps	<input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg	<input type="checkbox"/> Take 1 cap PO daily <input type="checkbox"/> _____	28 _____	No Refills No Refills

### Supportive Therapies

<input type="checkbox"/> Dexamethasone	<input type="checkbox"/> 2 mg <input type="checkbox"/> 4 mg	<input type="checkbox"/> Take _____ mg PO once weekly on days 1, 8, 15 and 22 of a 28 day cycle <input type="checkbox"/> _____	28 Day Supply _____	_____
<input type="checkbox"/> Hemady®	20 mg	<input type="checkbox"/> Take _____ mg PO once weekly on days 1, 8, 15 and 22 of a 28 day cycle <input type="checkbox"/> _____	28 Day Supply _____	_____
<input type="checkbox"/> Other				

By signing this form, you are authorizing BioPlus Specialty Pharmacy and its employees to serve as your designated agent in submitting clinical and other required information to third party payers with respect to this prescription and any refills or continuation of the same medication and dose for this patient. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee you should 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.

Prescriber's Signature (no stamps) Substitution Permitted

Date

Prescriber's Signature (no stamps) Dispense As Written

Date