

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	☐ Female ☐ Male	DEA #	NPI # License #

Clinical Information	
Diagnosis	ICD-10
Drug Allergies	Status: ☐ New ☐ Restart ☐ Continuing

Please Attach Supporting Labs and Provide Medication List

Prescription Information	
Indicate Type From PPAF (check one): ☐ Adult Female - Reproductive Potential (FRP) ☐ Adult Female - NOT of Reproductive Potential (FNRP) ☐ Adult Male ☐ Female Child - Reproductive Potential (FRP) ☐ Female Child - NOT of Reproductive Potential (FNRP) ☐ 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
☐ Pomalyst [®]	☐ 1 mg ☐ 2 mg ☐ 3 mg ☐ 4 mg	☐ Take 1 cap PO daily, days 1-21 of 28 day cycle ☐ _____	21 _____	No Refills No Refills
☐ Revlimid [®]	☐ 2.5 mg ☐ 5 mg ☐ 10 mg ☐ 15 mg ☐ 20 mg ☐ 25 mg	☐ Take 1 cap PO daily ☐ Take 1 cap PO daily, days 1-21 of 28 day cycle ☐ _____	28 21 _____	No Refills No Refills No Refills
☐ Thalomid [®] Supplied in blister packs of 28 caps	☐ 50 mg ☐ 100 mg ☐ 150 mg ☐ 200 mg	☐ Take 1 cap PO daily ☐ _____	28 _____	No Refills No Refills

Supportive Therapies

☐ Dexamethasone	☐ 2 mg ☐ 4 mg	☐ Take _____ mg PO once weekly on days 1, 8, 15 and 22 of a 28 day cycle ☐ _____	28 Day Supply _____	_____
☐ Hemady [®]	20 mg	☐ Take _____ mg PO once weekly on days 1, 8, 15 and 22 of a 28 day cycle ☐ _____	28 Day Supply _____	_____
☐ 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