

**PATIENT INFORMATION**

Name:		SSN:	DOB:	
Address:		City:	State:	ZIP:
Home Phone:	Cell:	Height:	Weight:	
Email:		Gender:	Female	Male

**INSURANCE INFORMATION (or attach copy of the cards)**

Primary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:

**CLINICAL INFORMATION**

Diagnosis:	Diagnosis Code (ICD-10):
Drug Allergies:	Status: <input type="checkbox"/> New <input type="checkbox"/> Restart <input type="checkbox"/> Continuing
<b>Required Labs</b>	Serum Creatinine: _____ eGFR/CrCL: _____ Date: _____

Patient Type (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

**Celgene Auth #:** \_\_\_\_\_ **Date Issued:** \_\_\_\_\_

**PRESCRIPTION INFORMATION (or attach a copy of the prescription)**

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> <b>POMALYST®</b> <input type="checkbox"/> <i>pomalidomide</i>	<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 on days 1-21, of a 28 day cycle <input type="checkbox"/> _____	21 _____	None
<input type="checkbox"/> <b>REVLIMID®</b> <input type="checkbox"/> <i>lenalidomide</i>	<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 on days 1-21, of a 28 day cycle <input type="checkbox"/> _____	28 21	None
<input type="checkbox"/> <b>THALOMID®</b> <i>(thalidomide)</i> <i>Supplied in blister packs of 28 caps</i>	<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 _____	None
<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 _____	_____
<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 _____	_____
<input type="checkbox"/> Other				

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution.  Dispense as written

**PHYSICIAN INFORMATION**

Prescriber Name:	Phone:	Fax:		
Office Contact:	Email:			
Address:	City:	State:	ZIP:	
NPI #:	Tax ID#:	Ship To:	<input type="checkbox"/> Patient	<input type="checkbox"/> MD Office
Prescriber Signature:	Date:			