



Carelon Company

Skip this form & e-prescribe! Select BioPlus from your EHR!

Oncology REMS

Phone: 833-ONC-EASY (662-3279) Fax: 800-269-5493 bioplusrx.com

Need By Date: _____ Ship To: ☐ Patient ☐ Office ☐ Other _____ Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back ☐ Supporting Labs ☐ Medication List

Patient Information		Prescriber Information	
Patient Name		Prescriber Name	
Address		Address	
City State ZIP		City State ZIP	
Main Phone	Alternate Phone	Phone	Fax
SSN		Contact Person	
Date of Birth	☐ Female ☐ Male	DEA #	NPI # License #

Clinical Information	
Diagnosis	ICD-10 (Required)
Patient Type (check one): Revlimid, Pomalyst, Thalomid ☐ 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	
Patient Type (check one): Zenbexus ☐ Females Who Can Become Pregnant ☐ Females Who Cannot Become Pregnant ☐ Adult Male	
To prevent delays and minimize phone calls please provide the following labs: Serum Creatinine: _____ eGFR/CrCL: _____ Date: _____ / _____ / _____	
Drug Allergies	Weight ☐ kg ☐ lbs Height ☐ ft ☐ in Status: ☐ New ☐ Restart ☐ Continuing
Celgene Authorization #	Date Issued

Med	Dose/Strength	Directions	Qty	Refills
☐ Pomalyst® ☐ (pomalidomide)	☐ 1mg ☐ 2mg ☐ 3mg ☐ 4mg	☐ Take 1 cap PO daily, days 1-21 of 28 day cycle ☐	21 _____	None None
☐ Revlimid® ☐ (lenalidomide)	☐ 2.5mg ☐ 5mg ☐ 10mg ☐ 15mg ☐ 20mg ☐ 25mg	☐ Take 1 cap PO daily ☐ Take 1 cap PO daily, days 1-21 of 28 day cycle ☐	28 21 _____	None None None
☐ Thalomid® (thalidomide) <i>Supplied in blister packs of 28 caps</i>	☐ 50mg ☐ 100mg	☐ Take at bedtime, at least 1 hour after the evening meal ☐	28 _____	None None
☐ Zenbexus™ (iberdomide)	☐ 0.75mg ☐ 1mg	☐ Take 1 capsule by mouth once daily on days 1-21 of a 28 day cycle ☐	21 _____	_____ _____
☐ Darzalex Faspro® (daratumumab, hyaluronidase)	☐ 1800mg-30,000 units/15mL	☐ Cycles 1 and 2: Inject 1800mg-30,000 units SUBQ on days 1, 8, 15, and 22 of each 28 day cycle ☐ Cycles 3, 4, 5 and 6: Inject 1800mg-30,000 units SUBQ on days 1 and 15 of each 28 day cycle ☐ Cycle 7 and beyond: Inject 1800mg-30,000 units SUBQ on day 1 of each 28 day cycle	#4 Vials #2 Vials #1 Vial _____	1 3 _____
☐ Dexamethasone	☐ 2mg ☐ 4mg	☐ Take 40mg by mouth once weekly on days 1, 8, 15 and 22 of a 28 day cycle ☐ Take 20mg by mouth once weekly	28 Day Supply 28 Day Supply _____	_____ _____

Supportive Therapies				
☐ Dexamethasone	☐ 2mg ☐ 4mg	☐ Take _____ mg PO once weekly on days 1, 8, 15 and 22 of a 28 day cycle ☐	_____ _____	_____ _____
☐ 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 payors 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