

Patient Information					
Last Name		First Name		Home Phone	
Home Address		City		State	
Shipping Address (if different from above)		City		State	
Social Security Number		Date of Birth		Gender (M/F)	
		Weight		Height	
Diagnosis ICD-10:					
Special Instructions (allergies, language preference, etc.)					
Primary Caregiver/Phone			Emergency Contact/Phone		

Healthcare Provider Information: *Indicates Required Field					
Practice/Facility Name		Prescriber First and Last Name*		Phone*	
Address*		City*		State*	
Prescriber NPI#*		Prescriber DEA#		Prescriber State License #	
Nurse/Key Contact		Phone or Pager Number		Email	

Celgene REMS Products	
<p><b>REVLIMID®</b> <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</p> <p><input type="checkbox"/> Take 1 capsule PO once daily. QTY: 28 0 Refills</p> <p><input type="checkbox"/> Take 1 capsule PO daily; days 1-21 of 28-day cycle. QTY: 21 0 Refills</p> <p><input type="checkbox"/> Other: _____ QTY: ___ 0 Refills</p>	<p><b>Risk Category</b></p> <p><input type="checkbox"/> ADULT Female, NOT of Reproductive Potential</p> <p><input type="checkbox"/> ADULT Female, Reproductive Potential</p> <p><input type="checkbox"/> ADULT Male</p> <p><input type="checkbox"/> Female CHILD, NOT of Reproductive Potential</p> <p><input type="checkbox"/> Female CHILD, Reproductive Potential</p> <p><input type="checkbox"/> Male CHILD</p> <p><b>Celgene Auth #:</b> _____</p> <p><b>Date Issued:</b> _____</p> <p><b>Confirmation #:</b> _____</p> <p><b>Date Issued:</b> _____</p>
<p><b>THALOMID®</b> <input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg</p> <p><input type="checkbox"/> Take 1 capsule PO once daily. QTY: 28 0 Refills</p> <p><input type="checkbox"/> Other: _____ QTY: ___ 0 Refills</p>	
<p><b>POMALYST®</b> <input type="checkbox"/> 1 mg <input type="checkbox"/> 2 mg <input type="checkbox"/> 3 mg <input type="checkbox"/> 4 mg</p> <p><input type="checkbox"/> Take 1 capsule PO once daily, days 1-21 of 28-day cycle. QTY: 21 0 Refills</p> <p><input type="checkbox"/> Other: _____ QTY: ___ 0 Refills</p>	

Other Medications			
Drug	Directions for Use (including cycle regimen, if any)	Qty	Refills
Drug	Directions for Use (including cycle regimen, if any)	Qty	Refills
Drug	Directions for Use (including cycle regimen, if any)	Qty	Refills

Insurance Information	
Fax a copy of patient's insurance card - both sides.	

\*\*\*When sending a referral please include all clinical information relevant to performing a prior authorization and copies of patient's insurance cards\*\*\*

Prescriber Signature: \_\_\_\_\_  DAW (Dispense as Written) Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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