Revlimid®/Pomalyst®/ Thalomid® Referral Form

Phone (888) 370.1724 Fax (877) 645.7514
10004 S. 152nd St, Suite A, Omaha NE 68138

AMBER™ SPECIALTY PHARMACY

Patient Information

Last Name	First Name	Home Phone	Work/Mobile Phone

Home Address	City	State	ZIP

Shipping Address (if different from above)	City	State	ZIP

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***	Fax

Address*	**City***	**State***	**ZIP***

Prescriber NPI#*	Prescriber DEA#	Prescriber State License #	Prescriber UPIN#

Nurse/Key Contact	Phone or Pager Number	Email

Celgene REMS Products

REVLIMID® ☐ 2.5 mg ☐ 5 mg ☐ 10 mg ☐ 15 mg ☐ 20 mg ☐ 25 mg

☐ Take 1 capsule PO once daily. QTY: 28 0 Refills
☐ Take 1 capsule PO daily; days 1-21 of 28-day cycle. QTY: 21 0 Refills
☐ Other:_____ QTY: ___ 0 Refills

THALOMID® ☐ 50 mg ☐ 100 mg ☐ 150 mg ☐ 200 mg

☐ Take 1 capsule PO once daily. QTY: 28 0 Refills
☐ Other:_____ QTY: ___ 0 Refills

POMALYST® ☐ 1 mg ☐ 2 mg ☐ 3 mg ☐ 4 mg

☐ Take 1 capsule PO once daily, days 1-21 of 28-day cycle. QTY: 21 0 Refills
☐ Other:_____ QTY: ___ 0 Refills

Risk Category

☐ ADULT Female, NOT of Reproductive Potential
☐ ADULT Female, Reproductive Potential
☐ ADULT Male

☐ Female CHILD, NOT of Reproductive Potential
☐ Female CHILD, Reproductive Potential
☐ Male CHILD

Celgene Auth #: _____
Date Issued: _____
Confirmation #: _____
Date Issued: _____

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** ____ /____ /____