Please fax both pages of completed form to your team at 888.302.1028.

To reach your team, call toll-free 844.516.3319.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Oncology REMS

accredo®

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name _____ Last name _____ Middle initial _____

Sex at birth: ☐ Male ☐ Female Preferred pronouns _____ Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ Email address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ Email address _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please specify _____

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Office/clinic/institution name _____

Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact email _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Deliver product to: ☐ Prescriber's office ☐ Patient's home

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____

Current weight _____ kg/lbs Height _____ inches/cm

BSA _____ m^2 Date obtained _____

Patient type from PPAF (check one): ☐ Adult Male ☐ Male Child ☐ Adult Female – NOT of Reproductive Potential

☐ NKDA ☐ Known drug allergies _____

Concurrent meds _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Strength/ Formulation	Directions	Quantity/Refills
☐ Pomalyst® (pomalidomide)	☐ 1mg capsule ☐ 2mg capsule ☐ 3mg capsule ☐ 4mg capsule	☐ Take _____capsule(s) daily ☐ Take _____capsule(s) for _____days on and _____days off --- **For Multiple Myeloma**: The recommended starting dose of Pomalyst is 4mg/day orally for Days 1 – 21 of repeated 28-day cycles. Pomalyst should be given in combination with dexamethasone. Dosing is continued or modified based upon clinical and laboratory findings. **Authorization #** _____ **Date** _____ **(To be filled in by healthcare provider)** **Patient type from PPAF (check one): ☐ Adult Male ☐ Male Child ☐ Adult Female – NOT of Reproductive Potential ☐ Adult Female – Reproductive Potential ☐ Female Child – NOT of Reproductive Potential ☐ Female Child – Reproductive Potential**	Quantity _____ No refills
☐ Revlimid® (lenalidomide)	☐ 2.5mg capsule ☐ 5mg capsule ☐ 10mg capsule ☐ 15mg capsule ☐ 20mg capsule ☐ 25mg capsule	☐ Take _____capsule(s) daily ☐ Take _____capsule(s) for _____days on and _____days off --- **Myelodysplastic Syndromes and Multiple Myeloma maintenance following autologous hematopoietic stem cell transplantation:** The recommended starting dose of Revlimid is 10mg/day with water. Dosing is continued or modified based upon clinical and laboratory findings. **Multiple Myeloma and Mantle Cell Lymphoma:** The recommended starting dose of Revlimid is 25mg/day orally for Days 1 – 21 of repeated 28-day cycles. Dosing is continued or modified based upon clinical and laboratory findings. **Authorization #** _____ **Date** _____ **(To be filled in by healthcare provider)** **Patient type from PPAF (check one): ☐ Adult Male ☐ Male Child ☐ Adult Female – NOT of Reproductive Potential ☐ Adult Female – Reproductive Potential ☐ Female Child – NOT of Reproductive Potential ☐ Female Child – Reproductive Potential**	Quantity _____ No refills
☐ Thalomid® (thalidomide)	☐ 50mg capsule ☐ 100mg capsule ☐ 150mg capsule ☐ 200mg capsule	☐ Take _____capsule(s) daily ☐ Take _____capsule(s) for _____days on and _____days off --- **Multiple Myeloma**: The recommended starting dose of Thalomid is 200mg/day orally with water for a 28-day treatment cycle. Dosing is continued or modified based upon clinical and laboratory findings. **Erythema Nodosum Leprosum**: The recommended starting dose of Thalomid is 100 to 300mg/day with water for an episode of cutaneous ENL. Up to 400mg/day for severe cutaneous ENL. Dosing is continued or modified based upon clinical and laboratory findings. **Authorization #** _____ **Date** _____ **(To be filled in by healthcare provider)** **Patient type from PPAF (check one): ☐ Adult Male ☐ Male Child ☐ Adult Female – NOT of Reproductive Potential ☐ Adult Female – Reproductive Potential ☐ Female Child – NOT of Reproductive Potential ☐ Female Child – Reproductive Potential**	Quantity _____ No refills
☐ Other			

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.
Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

_____ **Date** _____ **Dispense as written** _____ **Date** _____ **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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