Prescription & Enrollment Form

Celgene REMS

accredo®

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient's first name _____
Last name _____ Middle initial _____
Date of birth _____ ❑ Male ❑ Female Last 4 digits of SSN _____
Street address _____ Apt # _____
City _____ State _____ Zip _____
Parent/guardian (if applicable) _____
Cell phone _____ Other phone _____
E-mail address _____
Patient's primary language: ❑ English ❑ Other If other, please specify _____

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company _____ Phone _____
Insured's name _____
Insured's employer _____ Relationship to patient _____
Identification # _____ Policy/group # _____
Prescription card: ❑ Yes ❑ No If yes, carrier _____
Policy # _____ Group # _____
Is patient eligible for Medicare? ❑ Yes ❑ No
Does patient have a secondary insurance? ❑ Yes ❑ No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____
Prescriber's first name _____ Last name _____
Prescriber's title _____
If NP or PA, under direction of Dr. _____
Office contact and title _____
Office contact e-mail _____
Office/clinic/institution name _____
Clinic/hospital affiliation _____
Street address _____ Suite # _____
City _____ State _____ Zip _____
Phone _____ Fax _____
NPI # _____ License # _____

3 CLINICAL INFORMATION

Primary ICD-10 code: _____
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** ❑ **Adult Female – Reproductive Potential**
❑ **Female Child – NOT of Reproductive Potential** ❑ **Female Child – Reproductive Potential**
❑ NKDA ❑ Known drug allergies _____
Concurrent meds _____

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ Pomalyst® (pomalidomide)	❑ 1 mg capsule ❑ 2 mg capsule ❑ 3 mg capsule ❑ 4 mg capsule	❑ Take _____ capsule(s) daily ❑ Take _____ capsules (s) for _____ days on and _____ days off **For Multiple Myeloma**: The recommended starting dose of Pomalyst is 4 mg/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)	❑ 2.5 mg capsule ❑ 5 mg capsule ❑ 10 mg capsule ❑ 15 mg capsule ❑ 20 mg capsule ❑ 25 mg capsule	❑ Take _____ capsule(s) daily ❑ Take _____ capsules (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 10 mg/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 25 mg/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)	❑ 50 mg capsule ❑ 100 mg capsule ❑ 150 mg capsule ❑ 200 mg capsule	❑ Take _____ capsule(s) daily ❑ Take _____ capsules (s) for _____ days on and _____ days off **Multiple Myeloma**: The recommended starting dose of Thalomid is 200 mg/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 300 mg/day with water for an episode of cutaneous ENL. Up to 400 mg/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 Maximum of a 28-day supply
❑ Other _____ _____			

By signing below, I certify that the above therapy is medically necessary. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited. **Prescriber's signature (sign below) (Physician attests this is his/her legal signature. NO STAMPS)**

PHYSICIAN SIGNATURE REQUIRED

_____ _____ _____ _____
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.

Please fax completed form to the Oncology 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.

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