

REVLIMID® Patient Prescription Form

Phone: **888.763.5517** ■ Fax: **402.896.4862**

Today's Date _____ Date Prescription is Needed _____

Patient Information

Last Name _____ First Name _____
 Home Phone _____ Other Phone _____
 Home Address _____
 City _____ State _____ Zip _____
 Shipping Address (if different from above) _____

 Date of Birth _____ SS# / Patient ID # _____
 Language Preference: ☐ English ☐ Spanish ☐ Other
 Patient Diagnosis (ICD-9 Code) _____
 Patient Allergies _____
 Other Current Medications _____

Patient Type from PPAF (Check One)

- ☐ Adult Female — NOT of Childbearing Potential
☐ Adult Female — Childbearing Potential
☐ Adult Male
☐ Female Child — NOT of Childbearing Potential
☐ Female Child — Childbearing Potential
☐ Male Child

Insurance Information

Primary Insurance _____
 Phone _____
 Name / SSN of Insured _____
 ID Number _____
 Group Number _____
 Prescription Drug Card Number _____
Secondary Insurance _____
 Phone _____
 Name / SSN of Insured _____
 ID Number _____
 Group Number _____
 Prescription Drug Card Number _____
Other Insurance _____
 Phone _____
 Name / SSN of Insured _____
 ID Number _____
 Group Number _____
 Prescription Drug Card Number _____

Prescriber Information

Prescriber Name _____
 Prescriber State License # _____ NPI # _____
 UPIN # _____ DEA # _____
 Facility Name _____
 Address _____
 City _____ State _____ Zip _____
 Phone _____ Fax _____
 Office Contact Name _____
 Office Contact Phone Number _____

Medication

Please tape prescription here prior to faxing referral
 OR complete the following:

REVLIMID®

Dose	Quantity	Directions
☐ 2.5 mg	_____	_____
☐ 5 mg	_____	_____
☐ 10 mg	_____	_____
☐ 15 mg	_____	_____
☐ 25 mg	_____	_____

☐ Dispense as Written ☐ Substitution Permitted

NO REFILLS ALLOWED (Maximum Quantity = 28 days)

Prescriber Signature _____ Date _____
 Authorization # _____ Date _____
 (To be filled in by healthcare provider)
 Pharmacy Confirmation # _____ Date _____
 (To be filled in by pharmacy)

RECOMMENDED STARTING DOSE:

Myelodysplastic Syndromes: 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: The recommended starting dose of REVLIMID is 25 mg/day orally on Days 1-21 of repeated 28-day cycles. Dosing is continued or modified based upon clinical and laboratory findings.

Important Information about RevAssist

- To avoid fetal exposure, REVLIMID® (lenalidomide) is only available under a special restricted distribution program called "RevAssist®"
- Only prescribers registered with RevAssist® can prescribe REVLIMID® (lenalidomide)
- Only RevAssist® contract pharmacies can dispense REVLIMID® (lenalidomide)
- In order to receive REVLIMID® (lenalidomide), patients must enroll in RevAssist® and agree to comply with the requirements of the RevAssist® program
- Information about REVLIMID® (lenalidomide) and the RevAssist® program can be obtained by calling the Celgene Customer Care Center toll-free at 1.888.423.5436, or at www.REVLIMID.com

How to Fill a REVLIMID® (lenalidomide) Prescription

1. Healthcare provider (HCP) instructs the patient to complete the patient survey
2. HCP completes survey
3. HCP completes REVLIMID® Patient Prescription Form (on the front of this document)
4. HCP obtains RevAssist® authorization number
5. HCP Provides authorization number on patient prescription form
6. HCP faxes form, including prescription, to Amber Pharmacy (a RevAssist® contract pharmacy)
7. HCP advises patient that a representative from Amber Pharmacy will contact them
8. Amber Pharmacy conducts patient education
9. Amber Pharmacy calls for confirmation number
10. Amber Pharmacy ships REVLIMID® to patient with the FDA-approved MEDICATION GUIDE