

REVLIMID® (lenalidomide) Patient Prescription Form

Today's Date _____ Date Rx Needed _____

Patient Last Name _____ Patient First Name _____

Phone Number (____) _____

Shipping Address _____

City _____ State _____ Zip _____

Date of Birth _____ Patient ID# _____

Language Preference: English Spanish Other _____

Best Time to Call Patient: AM _____ PM _____

Patient Diagnosis _____

Patient Allergies _____

Other Current Medications _____

Prescriber Name _____

State License Number _____

Prescriber Phone Number (____) _____ Ext. _____

Fax Number (____) _____

Prescriber Address _____

City _____ State _____ Zip _____

Patient Type From PPAF (Check one)

- Adult Female – NOT of Reproductive Potential
- Adult Female – Reproductive Potential
- Adult Male
- Female Child – Not of Reproductive Potential
- Female Child – Reproductive Potential
- Male Child

PRESCRIPTION INSURANCE INFORMATION

(Fill out entirely and fax a copy of patient's insurance card, both sides)

Primary Insurance _____

Insured _____

Policy # _____

Group # _____

Phone # _____

Rx Drug Card # _____

Secondary Insurance _____

Insured _____

Policy # _____

Group # _____

Phone # _____

Rx Drug Card # _____

TAPE PRESCRIPTION HERE PRIOR TO FAXING REFERRAL, OR COMPLETE THE FOLLOWING:

Recommended Starting Dose: See below for dosage **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.

REVLIMID

Dose	Quantity
<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	_____

Directions

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)

How to Fill a REVLIMID® (lenalidomide) Prescription

1. Healthcare Provider (HCP) instructs female patients to complete initial patient survey
2. HCP completes survey
3. HCP completes patient prescription form
4. HCP obtains REVLIMID REMS® authorization number
5. HCP provides authorization number on patient prescription form
- 6. HCP faxes form, including prescription, to one of the Celgene Certified Pharmacy Network participants (see below)**
7. HCP advises patient that a representative from the certified pharmacy will contact them
8. Certified pharmacy conducts patient education
9. Certified pharmacy obtains confirmation number
10. Certified pharmacy ships REVLIMID to patient with MEDICATION GUIDE

Please see www.Celgene.com/PharmacyNetwork for the list of pharmacy participants

Information about REVLIMID and the REVLIMID REMS® program can be obtained by calling the Celgene Customer Care Center toll-free at **1-888-423-5436**, or at **www.CelgeneRiskManagement.com**.

