

THALOMID® (thalidomide) 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

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.

THALOMID

Dose	Quantity
<input type="checkbox"/> 50 mg	_____
<input type="checkbox"/> 100 mg	_____
<input type="checkbox"/> 150 mg	_____
<input type="checkbox"/> 200 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 THALOMID® (thalidomide) 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 THALOMID 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 THALOMID to patient with MEDICATION GUIDE

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

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

