

Revlimid® - Thalomid® - Pomalyst® Oral Oncology Rx Order Form

Patient Information (REQUIRED)

 Date: _____
 Patient Name: _____ Date of Birth: _____ Sex: M F Last 4 Digits of SSN: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Ph: _____ Cell Ph: _____ Email: _____
 Patient Weight: _____ lbs Patient Height: _____ Date Taken: _____ Allergies: _____

Pharmacy Benefit Manager (REQUIRED) Please provide copies of both sides of the patient's card

 PBM Name: _____ Rx BIN#: _____ PCN#: _____
 Rx Group#: _____ Member ID#: _____

Medical/Health Insurance Info. (REQUIRED) Please provide copies of both sides of the patient's card

 Primary: _____ Policy Holder: _____ Policy # _____ Ph: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Secondary: _____ Policy Holder: _____ Policy # _____ Ph: _____
 Address: _____ City: _____ State: _____ Zip: _____

Current Medication List

Prior Therapy Type: Velcade Cyclophosphamide Thalomid Revlimid Other _____

Clinical/Prescription information
 RevlimidREMS™ ThalomidREMS™ PomalystREMS™

 Physician Authorization#: _____ Date: _____
 Pharmacy Confirmation#: _____ Date: _____

Patient Risk Category

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

Rx Prescription

Oral Medication	Available Strengths (please check)						Directions	Quantity	Blister Pack
Revlimid®	<input type="checkbox"/> 2.5mg	<input type="checkbox"/> 5mg	<input type="checkbox"/> 10mg	<input type="checkbox"/> 15mg	<input type="checkbox"/> 20mg	<input type="checkbox"/> 25mg			<input type="checkbox"/> yes <input type="checkbox"/> no
Dexamethasone	<input type="checkbox"/> 4mg								<input type="checkbox"/> yes <input type="checkbox"/> no
Aspirin (enteric-coated)	<input type="checkbox"/> 81mg								<input type="checkbox"/> yes <input type="checkbox"/> no
Thalomid®	<input type="checkbox"/> 50mg	<input type="checkbox"/> 100mg	<input type="checkbox"/> 150mg	<input type="checkbox"/> 200mg					
Dexamethasone	<input type="checkbox"/> 4mg								<input type="checkbox"/> yes <input type="checkbox"/> no
Pomalyst®	<input type="checkbox"/> 1mg	<input type="checkbox"/> 2mg	<input type="checkbox"/> 3mg	<input type="checkbox"/> 4mg					<input type="checkbox"/> yes <input type="checkbox"/> no
Ninlaro®	<input type="checkbox"/> 2.3mg	<input type="checkbox"/> 3mg	<input type="checkbox"/> 4mg						

Diagnosis Information

 Primary Dx: _____ Dx Date (needed for funding): _____ ICD-9/10: _____
 Secondary Dx: _____ Dx Date (needed for funding): _____ ICD-9/10: _____

Physician Information

 Prescriber name: _____ Contact: _____
 Email: _____ Street: _____ City: _____
 State: _____ Zip: _____ Ph: _____ Fax: _____ NPI #: _____
 Tax ID # (needed for funding): _____ Prescriber Signature (required by law): _____ Date: _____

Prescription will be filled with generic unless prescriber writes "DAW" (dispense as written) in the box

Shipping Instructions

 Ship to: Physician's Office Patient's Home Other _____ Date Required: _____