POMALYST® (pomalidomide) Patient Prescription Form

Sales Rep: ____________________

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 #______________________________

Please send completed form to Acro Pharmaceutical Services

Fax: 877-381-3806

Tel: 800-906-7798

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 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

POMALYST Dose	Quantity	Directions
☐ **1 mg**	____________	
☐ **2 mg**	____________	
☐ **3 mg**	____________	
☐ **4 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)

For further information on POMALYST, please refer to the full Prescribing Information

How to Fill a POMALYST® (pomalidomide) 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 POMALYST 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 POMALYST to patient with MEDICATION GUIDE

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

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

Celgene