REVLIMID® (lenalidomide) Patient Prescription Form

PLEASE FAX COMPLETED FORM TO:
Acro Pharmaceutical Services
Fax: 877-381-3806

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 (ICD-9/ICD-10 Code)_____

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: 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**	**Directions**
☐ **2.5 mg**	_____	
☐ **5 mg**	_____	
☐ **10 mg**	_____	
☐ **15 mg**	_____	
☐ **20 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)

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

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™ (formerly known as the RevAssist® program) 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

ACRO Pharmaceutical Services
Ph: 800-906-7798
Fax: 877-381-3806

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.

Celgene