REVLIMID® (lenalidomide) Patient Prescription Form

Today's Date ________ **Date Rx Needed** ________

Patient Last Name ________ Patient First Name ________

Home Phone Number (____) ________

Other Phone Number (____) ________ Ext. ________

Home Address ________

City ________ State ________ ZIP ________

Shipping Address (If different from home address) ________

____

Date of Birth ________ SS# ________

Language Preference: ❑ English ❑ Spanish ❑ Other ________

Best Time to Call Patient: ❑ AM ________ ❑ PM ________

Patient Diagnosis (ICD-9 Code) ________

Patient Allergies ________

Other Current Medications ________

____

Prescriber Name ________

Physician State License Number ________

Physician DEA Number ________

Prescriber Phone Number (____) ________ Ext. ________

Fax Number (____) ________

Prescriber Address ________

____

City ________ State ________ ZIP ________

Office Contact Name ________

Office Contact Phone Number ________

Patient Type From PPAF (Check one)

❑ Adult Female—NOT of Childbearing Potential

❑ Adult Female—Childbearing Potential

❑ Adult Male

❑ Female Child—NOT of Childbearing Potential

❑ Female Child—Childbearing Potential

❑ Male Child

INSURANCE INFORMATION
(Fill out entirely or 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 # ________

I consent to have my medical information shared with Patient Support Solutions℠ (PSS℠) for reimbursement purposes. My consent is valid for a period no longer than 12 months from today's date and can be revoked at any time by contacting PSS℠ at 1-888-423-5436.

Patient Signature ________

Date ________

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

REVLIMID®

Dose	Quantity	Directions
❑ 5 mg	________	________
❑ 10 mg	________	________
❑ 15 mg	________	________
❑ 25 mg	________	________

Recommended Starting Dose: See below for dosage

❑ Dispense as Written **❑ Substitution Permitted**

NO REFILLS ALLOWED (Maximum Quantity = 28 days)

Prescriber Signature ________ **Date** ________

Authorization # ________
(To be filled in by healthcare provider)

Pharmacy Confirmation # ________
(To be filled in by pharmacy)

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: The recommended starting dose of REVLIMID® is 25 mg/day orally on Days 1–21 of repeated 28-day cycles. Dosing is continued or modified based upon clinical and laboratory findings.

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

IMPORTANT INFORMATION ABOUT RevAssist℠

- To avoid fetal exposure, REVLIMID® (lenalidomide) is only available under a special restricted distribution program called "RevAssist℠"
- Only prescribers registered with RevAssist℠ can prescribe REVLIMID® (lenalidomide)
- Only RevAssist℠ contract pharmacies can dispense REVLIMID® (lenalidomide)
- In order to receive REVLIMID® (lenalidomide), patients must enroll in RevAssist℠ and agree to comply with the requirements of the RevAssist℠ program
- Information about REVLIMID® (lenalidomide) and the RevAssist℠ program can be obtained by calling the Celgene Customer Care Center toll-free at 1-888-423-5436, or at www.REVLIMID.com

How to Fill a REVLIMID® (lenalidomide) Prescription

1. Healthcare provider (HCP) instructs patient to complete patient survey
2. HCP completes survey
3. HCP completes patient prescription form
4. HCP obtains RevAssist℠ authorization number
5. HCP provides authorization number on patient prescription form and patient signs, indicating consent to share medical information with PSS℠ for reimbursement support, if necessary
6. **HCP faxes form, including prescription, to one of the RevAssist℠ contract pharmacies (see below)**
7. HCP advises patient that a representative from a RevAssist℠ contract pharmacy will contact them
8. RevAssist℠ contract pharmacy conducts patient education
9. RevAssist℠ contract pharmacy calls for confirmation number
10. RevAssist℠ contract pharmacy ships REVLIMID® to patient with the FDA-approved MEDICATION GUIDE

RevAssist℠ Pharmacy Network

The RevAssist℠ Pharmacy Network is the list of contract pharmacies to be faxed the Patient Prescription Form

Biologics Inc.
Phone: 1-800-850-4306 (toll-free)
or 1-919-546-9810 (direct)
Fax: 1-919-546-9816

CuraScript Pharmacy
Phone: 1-866-883-2568
Fax: 1-866-883-2572

Walgreens Specialty Pharmacy
Phone: 1-888-782-8443
Fax: 1-866-617-6685

PharmaCare Specialty Pharmacy
Phone: 1-800-854-4299
Fax: 1-800-862-1249

Caremark Connect
Phone: 1-800-237-2767
Fax: 1-800-323-2445

Aetna Specialty Pharmacy
Phone: 1-866-782-2779
Fax: 1-866-329-2779

McKesson Specialty
Phone: 1-888-456-7274
Fax: 1-888-591-8482

BioScrip® Pharmacy
Phone: 1-877-842-5097
Fax: 1-866-368-9810

US Bioservices
Phone: 1-888-518-7246
Fax: 1-888-418-7246

Medco Special Care Pharmacy
Phone: 1-800-455-8340
Fax: 1-800-300-5208

Medmark® Pharmacy
Phone: 1-888-884-8714
Fax: 1-877-231-8302

Diplomat Specialty Pharmacy
Phone: 1-877-977-9118
Fax: 1-800-550-6272

Advanced Care Scripts
Phone: 1-866-681-7131
Fax: 1-866-679-7131

Axium Healthcare Pharmacy, Inc.
Phone: 1-888-315-3395
Fax: 1-888-315-3270

ivpcare
Phone: 1-800-424-9002
Fax: 1-800-874-9179

Accredo REVLIMID® Team
Phone: 1-800-601-7149
Fax: 1-800-590-1021

REVLIMID® is a registered trademark of Celgene Corporation.
RevAssist℠ is a service mark of Celgene Corporation.
Patient Support Solutions℠ (PSS℠) is a service mark of Celgene Corporation.
© 2006 Celgene Corporation 08/06 REV05071R2