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## Prescription & Enrollment Form Oncology REMS

*accredo*<sup>®</sup>  
677 Ala Moana Blvd., Suite 404,  
Honolulu, HI 96813-5412

### Four simple steps to submit your referral.

## 1 Patient Information



Please provide copies of front and back of the patient's medical and prescription insurance cards.

New patient    Current patient

Patient's first name \_\_\_\_\_ Last name \_\_\_\_\_ Middle initial \_\_\_\_\_

Preferred patient first name \_\_\_\_\_ Preferred patient last name \_\_\_\_\_

Sex at birth: Male Female Gender identity \_\_\_\_\_ Pronouns \_\_\_\_\_ Last 4 digits of SSN \_\_\_\_\_

Date of birth \_\_\_\_\_ Street address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email address \_\_\_\_\_

Parent/guardian (if applicable) \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email address \_\_\_\_\_

Alternate caregiver/contact \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email address \_\_\_\_\_

OK to leave message with alternate caregiver/contact

Patient's primary language: English Other If other, please specify \_\_\_\_\_

**Provider will read the following statement:** By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

## 2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date \_\_\_\_\_ Time \_\_\_\_\_ Date medication needed \_\_\_\_\_

Office/clinic/institution name \_\_\_\_\_

Prescriber's first name \_\_\_\_\_ Last name \_\_\_\_\_

Prescriber's title \_\_\_\_\_ If NP or PA, under direction of Dr. \_\_\_\_\_

Office phone \_\_\_\_\_ Fax \_\_\_\_\_ NPI # \_\_\_\_\_ License # \_\_\_\_\_

Office contact and title \_\_\_\_\_ Office contact email \_\_\_\_\_

Office street address \_\_\_\_\_ Suite # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Deliver product to: Prescriber's office Patient's home

## 3 Clinical Information

**Primary ICD-10 code (REQUIRED):** \_\_\_\_\_

Current weight \_\_\_\_\_ kg/lbs Height \_\_\_\_\_ inches/cm

BSA \_\_\_\_\_ m<sup>2</sup> Date obtained \_\_\_\_\_

Patient type from PPAF (check one): Adult Male Male Child Adult Female – NOT of Reproductive Potential

NKDA Known drug allergies \_\_\_\_\_

Concurrent meds \_\_\_\_\_

Patient's first name \_\_\_\_\_ Last name \_\_\_\_\_ Middle initial \_\_\_\_\_ Date of birth \_\_\_\_\_

Prescriber's first name \_\_\_\_\_ Last name \_\_\_\_\_ Phone \_\_\_\_\_

## 4 Prescribing Information

Medication	Strength/ Formulation	Directions	Quantity/Refills
Pomalyst® (pomalidomide)	1mg capsule 2mg capsule 3mg capsule 4mg capsule	Take _____ capsule(s) daily Take _____ capsule(s) for _____ days on and _____ days off  ----- <b>For Multiple Myeloma:</b> The recommended starting dose of Pomalyst is 4mg/day orally for Days 1 – 21 of repeated 28-day cycles. Dosing is continued or modified based upon clinical and laboratory findings. <b>Authorization # _____ Date _____ (To be filled in by healthcare provider)</b> <b>Patient type from PPAF (check one):</b> Adult Male Male Child Adult Female – NOT of Reproductive Potential Adult Female – Reproductive Potential Female Child – NOT of Reproductive Potential Female Child – Reproductive Potential	Quantity _____ No refills  <b>For Kaposi Sarcoma (KS):</b> The recommended starting dose of Pomalyst is 5mg/day orally for Days 1-21 of repeated 28-day cycles. Dosing is continued or modified based upon clinical and laboratory findings.
Revlimid® (lenalidomide)	2.5mg capsule 5mg capsule 10mg capsule 15mg capsule 20mg capsule 25mg capsule	Take _____ capsule(s) daily Take _____ capsule(s) for _____ days on and _____ days off  ----- <b>Myelodysplastic Syndromes and Multiple Myeloma maintenance following autologous hematopoietic stem cell transplantation:</b> The recommended starting dose of Revlimid is 10mg/day with water. Dosing is continued or modified based upon clinical and laboratory findings. <b>Multiple Myeloma and Mantle Cell Lymphoma:</b> The recommended starting dose of Revlimid is 25mg/day orally for Days 1 – 21 of repeated 28-day cycles. Dosing is continued or modified based upon clinical and laboratory findings. <b>Authorization # _____ Date _____ (To be filled in by healthcare provider)</b> <b>Patient type from PPAF (check one):</b> Adult Male Male Child Adult Female – NOT of Reproductive Potential Adult Female – Reproductive Potential Female Child – NOT of Reproductive Potential Female Child – Reproductive Potential	Quantity _____ No refills  <b>For Follicular or Marginal Zone Lymphoma:</b> The recommended starting dose of Revlimid is 20mg/day orally for Days 1-21 of repeated 28-day cycles. Dosing is continued or modified based upon clinical and laboratory findings.
Thalomid® (thalidomide)	50mg capsule 100mg capsule	Take _____ capsule(s) daily Take _____ capsule(s) for _____ days on and _____ days off  ----- <b>Multiple Myeloma:</b> The recommended starting dose of Thalomid is 200mg/day orally with water for a 28-day treatment cycle. Dosing is continued or modified based upon clinical and laboratory findings. <b>Erythema Nodosum Leprosum:</b> The recommended starting dose of Thalomid is 100 to 300mg/day with water for an episode of cutaneous ENL. Up to 400mg/day for severe cutaneous ENL. Dosing is continued or modified based upon clinical and laboratory findings. <b>Authorization # _____ Date _____ (To be filled in by healthcare provider)</b> <b>Patient type from PPAF (check one):</b> Adult Male Male Child Adult Female – NOT of Reproductive Potential Adult Female – Reproductive Potential Female Child – NOT of Reproductive Potential Female Child – Reproductive Potential	Quantity _____ No refills
Other			

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

**Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)**

**SIGN HERE**

Date

Dispense as written

Date

Substitution allowed

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.



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