Current as of 6/1/2013. This document may not be part of the latest approved REMS.

POMALYST® (pomalidomide) Patient Prescription Form

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 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 #____________________

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

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. 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)

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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

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

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