((POMALYST REMS™ logo)) Prescriber Enrollment Form

All prescribers must be certified to prescribe POMALYST® (pomalidomide). To become certified the prescriber must:

1. Complete the Prescriber Enrollment Form, which is required for POMALYST REMS™ certification.
2. Agree to steps on the following page that must be followed with every patient.

To submit this form electronically, please visit www.CelgeneRiskManagement.com or access the Celgene mobile app.

To submit this form via fax, please complete the following page and fax it to 1-888-432-9325.

POMALYST is contraindicated in pregnant females and females capable of becoming pregnant. Females of reproductive potential may be treated with POMALYST provided adequate precautions are taken to avoid pregnancy.

Please review the steps on the following page that must be followed with every patient.
POMALYST is only available under a restricted distribution program, POMALYST REMS™.

((POMALYST logo))
POMALYST REMS™ Prescriber Enrollment Form

When prescribing POMALYST® (pomalidomide), I agree to:

• Provide patient counseling on the benefits and risks of POMALYST therapy, including Boxed Warnings

• Submit a completed POMALYST® (pomalidomide) Patient-Physician Agreement Form for each new patient

• Provide contraception and emergency contraception counseling with each new prescription prior to and during POMALYST treatment

• Provide scheduled pregnancy testing for females of reproductive potential and verify negative pregnancy test results prior to writing a new prescription or subsequent prescriptions

• Report any pregnancies in female patients or female partners of male patients prescribed POMALYST immediately to Celgene Drug Safety (or Celgene Customer Care Center)

• Complete a mandatory and confidential prescriber survey online or by telephone for all patients and obtain a new authorization number for each prescription written and include this authorization number on the prescription

• Facilitate female patient compliance with an initial mandatory confidential patient survey online or by telephone

• Prescribe no more than a 4-week (28-day) supply, with no automatic refills or telephone prescriptions

• Contact a POMALYST REMS™ certified pharmacy to fill the prescription

• Return to Celgene all POMALYST capsules that are returned by patients. Shipping fees will be paid by Celgene Corporation. To arrange returns, call the Celgene Customer Care Center

• Remind patients to return all POMALYST capsules to Celgene Corporation or their POMALYST prescriber, or to the pharmacy that dispensed the POMALYST to them

• Re-enroll patients in the POMALYST REMSTM program if POMALYST is required and previous therapy with POMALYST has been discontinued for 12 consecutive months
Please fill out the spaces below completely.

Prescriber Name ____________________________________________________________

Degree: MD/DO/PA/NP/Fellow/Medical Resident Specialty _______________________

Prescriber Identification Number (eg, DEA Number, Social Security Number, NPI Number, etc.)
____________________________________________________________

Please indicate which office(s) will receive POMALYST REMS™ materials and updates:

• Primary Office Name____________________________________________________
  Attention ______________________________________________________________
  Address ________________________________________________________________
  City_________________________ State _______________ZIP Code _____________
  Phone ________________________Ext._______ Fax_________________________
  Email Address__________________________________________________________

• Secondary Office Name__________________________________________________
  Attention ______________________________________________________________
  Address ________________________________________________________________
  City_________________________ State _______________ZIP Code _____________
  Phone ________________________Ext._______ Fax_________________________
  Email Address__________________________________________________________

I understand that if I fail to comply with all requirements of the POMALYST REMS™ program, my prescriptions for POMALYST® (pomalidomide) will not be honored at certified pharmacies.

Prescriber Signature ____________________________Date ______________________

Return this form to the Celgene Customer Care Center via fax or mail.

Mail to: Celgene Customer Care Center, 86 Morris Avenue, Summit, NJ 07901

Phone: 1-888-423-5436

Fax: 1-888-432-9325

www.CelgeneRiskManagement.com