

Patient		Prescriber
Name		Name
Identification Number		Identification Number
Address		Address
Telephone Number		Telephone Number
Date of Birth	Sex	Fax Number
Risk Category Menstruating: Surgical Menopause: Natural Menopause (24 months):		
Diagnosis		
Patient or Authorized Representative's Signature: Signature Date:		Prescriber's Signature: Signature Date:

Prescriber, please fax all pages of the completed form to **1-888-432-9325**.

Give a copy of the form to the patient.

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**POMALYST® (pomalidomide) Patient-Physician Agreement Form**

**Adult Female Who Can Not Get Pregnant**

Please read the following statements carefully.

**Your healthcare provider has prescribed POMALYST for you. POMALYST is available only through a restricted distribution program called the POMALYST Risk Evaluation and Mitigation Strategy (REMS). Before taking POMALYST, you must read and agree to all of the instructions in the POMALYST REMS® program.**

**Any unborn baby of a female taking POMALYST can have severe birth defects or even die.**

Blood clots in your arteries (heart attacks and strokes), veins (deep vein thrombosis) and lungs (pulmonary embolism) can happen if you take POMALYST.

For more information, please see the POMALYST Medication Guide.

#### INSTRUCTIONS

*Before starting your treatment with POMALYST, you will need to:*

1. Complete sections 1 and 2 of this form and sign and date on page 5.
2. Read the POMALYST REMS® materials contained in the **Patient Resource Pack**.
3. Keep a copy of this form for your records.

#### Authorized Representatives:

If the authorized representative does not have the power of attorney, a **signed and dated letter from the prescriber, on the prescriber's letterhead, must be submitted to the Celgene Customer Care Center, along with the POMALYST® (pomalidomide) Patient-Physician Agreement Form**. This letter must contain the following: a statement that the incompetent patient lacks the capacity to complete the POMALYST® (pomalidomide) Patient-Physician Agreement Form, including identification of the medical condition causing the incapacity; the name and address of the authorized representative; the authorized representative's relationship to the patient; and an opinion that the authorized representative accepts responsibility for the patient's compliance with the POMALYST REMS® program and is authorized to consent to treatment with POMALYST on behalf of the patient.

For more information, visit [www.CelgeneRiskManagement.com](http://www.CelgeneRiskManagement.com), or call the Celgene Customer Care Center at 1-888-423-5436.

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# POMALYST® (pomalidomide) Patient-Physician Agreement

## Adult Female Who Can Not Get Pregnant

Please read the following statements carefully. Mark the box (with an "X") if you agree with the statement. Please do not mark or write outside of designated areas.

### Section 1. Patient Agreement

#### I understand and confirm that:

- POMALYST can cause severe birth defects or death to unborn babies of females taking POMALYST
- I am not pregnant
- I am not able to get pregnant because:
  - I have had both of my ovaries and/or my uterus removed, or
  - I have been in natural menopause for at least 2 years
- My POMALYST prescription is **only** for me and is not to be shared with others
- I have read and understood the POMALYST Patient Guide to the POMALYST REMS® Program and/or educational materials, including the Medication Guide. These materials include information about the possible health problems and side effects that POMALYST may cause
- My healthcare provider has reviewed this information with me and answered any questions I have asked
- I may be contacted by Celgene to assist with the POMALYST REMS® program

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**POMALYST® (pomalidomide) Patient-Physician Agreement Form**

**Adult Female Who Can Not Get Pregnant**

**I will:**

- I will complete the mandatory confidential survey every 6 months while taking POMALYST
- I will keep my POMALYST prescription out of the reach of children
- I will return any unused POMALYST capsules for disposal to Celgene by calling **1-888-423-5436**. Celgene will pay for the shipping costs. I understand that Celgene cannot give me a refund for the capsules I did not take. Unused POMALYST capsules can also be returned to my POMALYST prescriber, or to the pharmacy that dispensed the POMALYST to me

**I will not:**

- I will **not** share my POMALYST capsules with anyone even if they have symptoms like mine
- I will **not** donate blood while taking POMALYST (including dose interruptions) and for 4 weeks after stopping POMALYST

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# POMALYST® (pomalidomide) Patient-Physician Agreement Form

## Adult Female Who Can Not Get Pregnant

### Section 2. Authorization

I understand and confirm that:

- By signing this authorization, I allow my healthcare providers and pharmacies to share my medical and other health information with Celgene Corporation and other companies that Celgene works with to:
  - Coordinate the delivery of products and services available from pharmacies and Celgene patient assistance programs, including Celgene Patient Support<sup>®</sup>, and other companies
  - Analyze data for internal business purposes on the use of POMALYST
  - Evaluate the effectiveness of the POMALYST REMS<sup>®</sup> program
  - Use in any other manner as required or permitted by law
  - Provide me with information about POMALYST or my condition
- This authorization will remain in effect for 12 months after I stop POMALYST. However, it may be revoked (cancelled) earlier by me, at any time, once I inform my healthcare provider that I will no longer be a part of the POMALYST REMS<sup>®</sup> program
- Once my information is shared as noted above, and to process and coordinate the delivery of product, there is no guarantee that the person receiving the information will not share it with another party
- I may refuse to sign this authorization, which means that I do not want to participate in the POMALYST REMS<sup>®</sup> program. I understand that by refusing to participate in POMALYST REMS<sup>®</sup> program, I will not be able to receive POMALYST. However, I understand that I can speak with my healthcare provider about other treatment options for my condition
- Upon signing this form, I authorize my healthcare provider to begin my treatment with POMALYST



Pomalyst REMS<sup>®</sup>



POMALYST<sup>®</sup> is a registered trademark of Celgene Corporation. POMALYST REMS<sup>®</sup> is a trademark of Celgene Corporation.

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**POMALYST® (pomalidomide) Patient-Physician Agreement Form**

**Adult Female Who Can Not Get Pregnant**

**Section 3. Authorization to Start Treatment**

I have read the information on this form or it has been read aloud to me in the language of my choice. I understand that if I do not follow all of the instructions regarding the POMALYST REMS® program, I will not be able to receive POMALYST. I also understand that the information I provide on this form and as part of the surveys I will complete during treatment will be known by the manufacturer of POMALYST and the Food and Drug Administration (FDA).

**I agree that the prescriber has fully explained to the patient the nature, purpose, and risks of the treatment described above, especially the potential risks to females who can get pregnant. The prescriber has asked the patient if she has any questions regarding her treatment with POMALYST and has answered those questions to the patient’s and prescriber’s mutual satisfaction. Both patient and prescriber certify that they will comply with all of their obligations and responsibilities as described under the POMALYST REMS® program.**

Patient	Prescriber
<i>Name</i>	<i>Name</i>
<i>Identification Number</i>	<i>Identification Number</i>
<i>Address</i>	<i>Address</i>

<i>Telephone Number</i>		<i>Telephone Number</i>
<i>Date of Birth</i>	<i>Sex</i>	<i>Fax Number</i>
<i>Risk Category</i>		
<p style="text-align: center;">Menstruating:</p> <p style="text-align: center;">Surgical Menopause:</p> <p style="text-align: center;">Natural Menopause (24 months):</p>		
<i>Diagnosis</i>		
<i>Patient or Authorized Representative's Signature:</i>		<i>Prescriber's Signature :</i>
<i>Signature Date:</i>		<i>Signature Date:</i>

Prescriber, please fax all pages of the completed form to **1-888-432-9325**.

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