

POMALYST® (pomalidomide) Patient Prescription Form

Today's Date _____ Date Rx Needed _____	Prescriber Name _____
Patient Last Name _____ Patient First Name _____	State License Number _____
Phone Number (____) _____	Prescriber Phone Number (____) _____ Ext. _____
Shipping Address _____	Fax Number (____) _____
City _____ State _____ Zip _____	Prescriber Address _____
Date of Birth _____ Patient ID# _____	_____
Language Preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____	City _____ State _____ Zip _____
Best Time to Call Patient: <input type="checkbox"/> AM _____ <input type="checkbox"/> PM _____	Patient Type From PPAF (Check one)
Patient Diagnosis _____	<input type="checkbox"/> Adult Female – NOT of Reproductive Potential
Patient Allergies _____	<input type="checkbox"/> Adult Female – Reproductive Potential
_____	<input type="checkbox"/> Adult Male
Other Current Medications _____	<input type="checkbox"/> Female Child – Not of Reproductive Potential
	<input type="checkbox"/> Female Child – Reproductive Potential
	<input type="checkbox"/> 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 # _____

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. POMALYST should be given in combination with dex amethasone. Dosing is continued or modified based upon clinical and laboratory findings

POMALYST

Dose	Quantity	Directions
<input type="checkbox"/> 1 mg _____	_____	
<input type="checkbox"/> 2 mg _____	_____	
<input type="checkbox"/> 3 mg _____	_____	
<input type="checkbox"/> 4 mg _____	_____	

Dispense as Written Substitution Permitted

NO REFILLS ALLOWED (Maximum Quantity = 28 days)

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

APPEARS THIS WAY ON ORIGINAL

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.



POMALYST® is a registered trademark of Celgene Corporation. POMALYST REMS® is a trademark of Celgene Corporation.

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