

# POMALYST® (pomalidomide)

## Patient Prescription Form – Veterans Administration (VA) ONLY

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 Diagnosis _____	<b>Patient Type From PPAF (Check one)</b>
Patient Allergies _____	<input type="checkbox"/> Adult Female – NOT of Reproductive Potential
_____	<input type="checkbox"/> Adult Female – Reproductive Potential
Other Current Medications _____	<input type="checkbox"/> Adult Male
_____	<input type="checkbox"/> Female Child – Not of Reproductive Potential
	<input type="checkbox"/> Female Child – Reproductive Potential
	<input type="checkbox"/> Male Child

**VA Pharmacy Information (Fill out entirely)**

VA Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

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

VA Pharmacist Name \_\_\_\_\_

Phone # \_\_\_\_\_

Fax # \_\_\_\_\_

McKesson Specialty Distribution Account #  
\_\_\_\_\_

**Shipping Information**

Check below for direct delivery to patient. If any information is omitted, product will be shipped to the VA Pharmacy.

Patient

Name \_\_\_\_\_

Address \_\_\_\_\_

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

Phone \_\_\_\_\_

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. 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	_____	_____

## *How to Fill POMALYST® (pomalidomide)*

### *Prescription in the Veterans Administration (VA)*

1. Healthcare Provider (HCP) instructs female patients to complete initial patient survey
2. HCP completes survey
3. HCP completes patient prescription form (include cell number for patient if possible)
4. HCP obtains POMALYST REMS® authorization number
5. HCP provides authorization number on patient prescription form
6. HCP sends prescription to the VA Pharmacy

The following information must be filled in:

- Rx must include McKesson Specialty Distribution account number
- Rx must include VA address (Name, Street, City, State, ZIP)
- Rx must include VA Pharmacist contact information (Name, Phone and Fax #)

7. VA Pharmacist faxes the form, including prescription, to:

The POMALYST REMS® certified OncologyRx Care Advantage Specialty at 1-855-637-9446

8. HCP advises patient that a representative from POMALYST REMS® certified pharmacy will be in contact
9. The POMALYST REMS® certified OncologyRx Care Advantage Pharmacist conducts patient education
10. The POMALYST REMS® certified OncologyRx Care Advantage Pharmacist obtains confirmation number
11. The POMALYST REMS® certified OncologyRx Care Advantage Pharmacist ships POMALYST to the VA Pharmacy or directly to the patient with MEDICATION GUIDE

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## *POMALYST REMS® Veterans Administration (VA) Pharmacy*

**OncologyRx Care Advantage** Phone: 1-855-637-9433

Fax: 1-855-637-9446

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](http://www.CelgeneRiskManagement.com).



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