Natural Menopause (24 months):	
Diagnosis	
Patient or Authorized Representative's Signature: *Signature Date:*	*Prescriber's Signature :* *Signature Date:*

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

Give a copy of the form to the parent/guardian.

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REVLIMID® (lenalidomide) Patient-Physician Agreement Form

Adult Male

Please read the following statements carefully.

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

If a female you have sex with is pregnant or becomes pregnant by you while you are taking REVLIMID, it is important for you to know that your unborn baby can have severe birth defects or even die.

REVLIMID causes low white blood cells (neutropenia) and low platelets (thrombocytopenia) in most patients.

REVLIMID causes a higher chance for blood clots in your arteries (heart attacks and strokes), veins (deep vein thrombosis) and lungs (pulmonary embolism). To reduce this increased risk, most people who take REVLIMID will also take a blood thinner medicine.

For more information, please see the REVLIMID Medication Guide.

INSTRUCTIONS

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

1. Complete sections 1 and 2 of this form and sign and date on page 6.
2. Read the REVLIMID 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 REVLIMID® (lenalidomide) Patient-Physician Agreement Form.** This letter must contain the following: a statement that the incompetent patient lacks the capacity to complete the REVLIMID® (lenalidomide) 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 REVLIMID REMS® program and is authorized to consent to treatment with REVLIMID on behalf of the patient.

For more information, visit **www.CelgeneRiskManagement.com**, or call the Celgene Customer Care Center at **1-888-423-5436.**

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REVLIMID® (lenalidomide) Patient-Physician Agreement Form

Adult Male

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:

❒ REVLIMID can cause severe birth defects or death to my unborn baby if I have sex with a female who is pregnant or who is able to get pregnant during my treatment

- ❒ My semen may contain REVLIMID even after I stop treatment. I must use a latex or synthetic condom **every time** I have sex with a female who is pregnant or who is able to get pregnant while taking REVLIMID (including dose interruptions), and for 4 weeks after stopping REVLIMID
- ❒ Not having sex is the only birth control method that is 100% effective
- ❒ My REVLIMID prescription is **only** for me and is not to be shared with others
- ❒ I have read and understood the REVLIMID Patient Guide to the REVLIMID REMS® Program and/or educational materials, including the Medication Guide. These materials include information about the possible health problems and side effects that REVLIMID 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 REVLIMID REMS® program

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REVLIMID® (lenalidomide) Patient-Physician Agreement Form

Adult Male

❒ I must use a latex or synthetic condom **every time** I have sex with a female who is pregnant or who is able to get pregnant, even if I have had a successful vasectomy (tying of the tubes to prevent the passing of sperm)

❒ I will use a latex or synthetic condom **every time** I have sex with a female who is pregnant or who is able to get pregnant:

- While taking REVLIMID
- During breaks (dose interruptions)
- For 4 weeks after stopping REVLIMID

❒ I will call my healthcare provider right away if:

- I have unprotected sex with a female who is pregnant or who is able to get pregnant
- I think—**for any reason**—that my sexual partner is pregnant or may be pregnant
- My partner becomes pregnant or thinks she may be pregnant

If my healthcare provider is not available I will call the Celgene Customer Care Center at **1-888-423-5436**

❒ I will complete the mandatory confidential monthly survey while taking REVLIMID

❒ I will keep my REVLIMID prescription out of the reach of children

❒ I will return any unused REVLIMID 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 REVLIMID capsules can also be returned to my REVLIMID prescriber, or to the pharmacy who dispensed the REVLIMID to me

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Reference ID: 3921494

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REVLIMID® (lenalidomide) Patient-Physician Agreement Form
Adult Male

❒ I will **not** share my REVLIMID capsules with anyone even if they have symptoms like mine

❒ I will **not** donate blood or sperm while taking REVLIMID during breaks (dose interruptions) and for 4 weeks after stopping REVLIMID

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®, and other companies
- Analyze data for internal business purposes on the use of REVLIMID
- Evaluate the effectiveness of the REVLIMID REMS® program
- Use in any other manner as required or permitted by law
- Provide me with information about REVLIMID or my condition

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REVLIMID® (lenalidomide) Patient-Physician Agreement Form

Adult Male

- ❒ This authorization will remain in effect for 12 months after I stop REVLIMID. 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 REVLIMID REMS® 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 REVLIMID REMS® program. I understand that by refusing to participate in the REVLIMID REMS® program, I will not be able to receive REVLIMID. 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 REVLIMID**

RevlimidREMS®

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REVLIMID® (lenalidomide) Patient-Physician Agreement Form

Adult Male

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 REVLIMID REMS® program, I will not be able to receive REVLIMID. 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 REVLIMID 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 he has any questions regarding his treatment with REVLIMID (including appropriate birth control methods) 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 REVLIMID REMS® program.

Patient	Prescriber
Name	*Name*
Identification Number	*Identification Number*
Address	*Address*
Telephone Number	*Telephone Number*
Date of Birth	*Fax Number*
Sex	
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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