

THALOMID[®] (thalidomide) Patient Prescription Form

Today's Date _____ Date Rx Needed _____
 Patient Last Name _____ Patient First Name _____
 Phone Number (____) _____
 Shipping Address _____
 City _____ State _____ Zip _____
 Date of Birth _____ Patient ID# _____
 Language Preference: English Spanish
 Other _____
 Best Time to Call Patient: AM _____ PM _____
 Patient Diagnosis _____
 Patient Allergies _____

 Other Current Medications _____

Prescriber Name _____
 State License Number _____
 Prescriber Phone Number (____) _____
 Fax Number (____) _____
 Prescriber Address _____
 City _____ State _____ Zip _____
Patient Type From PPAF (Check one)
 Adult Female – NOT of Reproductive Potential
 Adult Female – Reproductive Potential
 Adult Male
 Female Child – Not of Reproductive Potential
 Female Child – Reproductive Potential
 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 # _____

For further information on THALOMID, 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 THALOMID is 200 mg/day orally with water for a 28-day treatment cycle. Dosing is continued or modified based upon clinical and laboratory findings.

Erythema Nodosum Leprosum: The recommended starting dose of THALOMID is 100 to 300 mg/day with water for an episode of cutaneous ENL. Up to 400 mg/day for severe cutaneous ENL. Dosing is continued or modified based upon clinical and laboratory findings.

THALOMID

Dose	Quantity	Directions
<input type="checkbox"/> 50 mg	_____	_____
<input type="checkbox"/> 100 mg	_____	_____
<input type="checkbox"/> 150 mg	_____	_____
<input type="checkbox"/> 200 mg	_____	_____

Dispense as Written Substitution Permitted

NO REFILLS ALLOWED (Maximum Quantity = 28 days)

Prescriber Signature _____ Date _____

Authorization # _____ Date _____

(To be filled in by healthcare provider)

Pharmacy Confirmation # _____ Date _____

(To be filled in by pharmacy)

How to Fill a THALOMID® (thalidomide) 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 THALOMID 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 THALOMID to patient with MEDICATION GUIDE

Please see www.Celgene.com/PharmacyNetwork for the list of pharmacy participants

Information about THALOMID and the THALOMID REMS® program can be obtained by calling the Celgene Customer Care Center toll-free at 1-888-423-5436, or at www.CelgeneRiskManagement.com.



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7/17

REMS-THA16909