Please read the following statements carefully.

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

Any unborn baby of a girl taking THALOMID can have severe birth defects or even die.

THALOMID causes a higher chance for blood clots in your veins (deep vein thrombosis) and lungs (pulmonary embolism).

For more information, please see the THALOMID Medication Guide.

INSTRUCTIONS

Before your child starts treatment with THALOMID, you will need to:

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

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

*Throughout this form, the word child includes any child of whom you are the parent or guardian.

For Example Purposes Only: Call 1-888-423-5436 for patient enrollment information.
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:

☐ THALOMID can cause severe birth defects or death to unborn babies of females taking THALOMID

☐ My child is not pregnant

☐ My child is not able to get pregnant because she has not yet started her period (is not menstruating)

☐ My child’s THALOMID prescription is only for her and is not to be shared with others

☐ We have read and understood the THALOMID Patient Guide to the THALOMID REMS® Program and/or educational materials, including the Medication Guide. These materials include information about the possible health problems and side effects that THALOMID may cause

☐ My child’s healthcare provider has reviewed this information with us and answered any questions we have asked

☐ We may be contacted by Celgene to assist with the THALOMID REMS® program

For Example Purposes Only: Call 1-888-423-5436 for patient enrollment information.
I will tell my child that:

☐ We will complete the mandatory confidential monthly survey while my child is taking THALOMID

☐ We will keep my child’s THALOMID prescription out of the reach of other children

☐ We will return any unused THALOMID 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 my child did not take. Unused THALOMID capsules can also be returned to my child’s THALOMID prescriber, or to the pharmacy that dispensed the THALOMID to my child

☐ She must **not** share her THALOMID capsules with anyone even if they have symptoms like hers

☐ She must **not** donate blood while taking THALOMID (including dose interruptions) and for 4 weeks after stopping THALOMID

For Example Purposes Only: Call 1-888-423-5436 for patient enrollment information.
I understand that my child's information will be shared with Celgene for the THALOMID REMS® Program. Celgene may also use the information for business purposes, to the extent permitted by applicable law.

☐ Upon signing this form, I authorize my child's healthcare provider to begin my child’s treatment with THALOMID

THALOMID® and THALOMID REMS® are registered trademarks of Celgene Corporation.
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 my child does not follow all of the instructions regarding the THALOMID REMS® program, she will not be able to receive THALOMID. I also understand that the information we provide on this form and as part of the surveys we will complete during treatment will be known by the manufacturer of THALOMID and the Food and Drug Administration (FDA).

I agree that the prescriber has fully explained to the patient and her parent/guardian 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 and her parent/guardian if they have any questions regarding the child’s treatment with THALOMID and has answered those questions to the patient’s, parent/guardian’s, and prescriber’s mutual satisfaction. The patient, parent/guardian, and prescriber certify that they will comply with all of their obligations and responsibilities as described under the THALOMID REMS® program.

☐ I would like to receive THALOMID REMS® educational materials. Please mail materials to the address provided on this Patient-Physician Agreement Form.

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<thead>
<tr>
<th>Patient</th>
<th>Prescriber</th>
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<td>Name</td>
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<td>Identification Number</td>
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<td>Address</td>
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<td>Telephone Number</td>
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<td>Date of Birth</td>
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<td>Risk Category</td>
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<td>Menstruating:</td>
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<td>Surgical Menopause:</td>
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<td>Natural Menopause (24 months):</td>
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<td>Diagnosis</td>
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<td>Patient or Authorized Representative’s Signature</td>
<td>Prescriber’s Signature</td>
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<td>Signature Date</td>
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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.

For Example Purposes Only: Call 1-888-423-5436 for patient enrollment information.