



# Revlimid®/Pomalyst®/Thalomid® Referral Form

Phone (888) 763.5517 Fax (402) 896.4862  
10004 S. 152nd St, Suite A, Omaha NE 68138

## Patient Information

Last Name		First Name		Home Phone		Work/Mobile Phone	
Home Address				City		State	ZIP
Shipping Address (if different from above)				City		State	ZIP
Social Security Number		Date of Birth		Gender (M/F)	Weight	Height	<b>Diagnosis ICD-10:</b>
Special Instructions (allergies, language preference, etc.)							
Primary Caregiver/Phone				Emergency Contact/Phone			

## Healthcare Provider Information: \*Indicates Required Field

Practice/Facility Name		Prescriber First and Last Name*		Phone*		Fax	
Address*				City*		State*	ZIP*
Prescriber NPI#*		Prescriber DEA#		Prescriber State License #		Prescriber UPIN#	
Nurse/Key Contact				Phone or Pager Number		Email	

## Celgene REMS Products

<b>REVLIMID®</b> <input type="checkbox"/> 2.5 mg <input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 15 mg <input type="checkbox"/> 20 mg <input type="checkbox"/> 25 mg <input type="checkbox"/> Take 1 capsule PO once daily. QTY: 28 0 Refills <input type="checkbox"/> Take 1 capsule PO daily; days 1-21 of 28-day cycle. QTY: 21 0 Refills <input type="checkbox"/> Other: _____ QTY: ___ 0 Refills	<b>Risk Category</b> <input type="checkbox"/> ADULT Female, NOT of Reproductive Potential <input type="checkbox"/> ADULT Female, Reproductive Potential <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 <b>Celgene Auth #:</b> _____ <b>Date Issued:</b> _____ <b>Confirmation #:</b> _____ <b>Date Issued:</b> _____
<b>THALOMID®</b> <input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg <input type="checkbox"/> Take 1 capsule PO once daily. QTY: 28 0 Refills <input type="checkbox"/> Other: _____ QTY: ___ 0 Refills	
<b>POMALYST®</b> <input type="checkbox"/> 1 mg <input type="checkbox"/> 2 mg <input type="checkbox"/> 3 mg <input type="checkbox"/> 4 mg <input type="checkbox"/> Take 1 capsule PO once daily, days 1-21 of 28-day cycle. QTY: 21 0 Refills <input type="checkbox"/> Other: _____ QTY: ___ 0 Refills	

## Other Medications

Drug	Directions for Use (including cycle regimen, if any)	Qty	Refills
Drug	Directions for Use (including cycle regimen, if any)	Qty	Refills
Drug	Directions for Use (including cycle regimen, if any)	Qty	Refills

## Insurance Information

Fax a copy of patient's insurance card - both sides.

\*\*\*When sending a referral please include all clinical information relevant to performing a prior authorization and copies of patient's insurance cards\*\*\*

Prescriber Signature: \_\_\_\_\_  DAW (Dispense as Written) Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.