

# REVLIMID® (lenalidomide) 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 (ICD-9 Code) \_\_\_\_\_  
 Patient Allergies \_\_\_\_\_  
 \_\_\_\_\_  
 Other Current Medications \_\_\_\_\_  
 \_\_\_\_\_

Prescriber Name \_\_\_\_\_  
 State License Number \_\_\_\_\_  
 Prescriber Phone Number ( ) \_\_\_\_\_ Ext. \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_  
 Prescriber Address \_\_\_\_\_  
 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Patient Type Form PPAF** (Check one)  
 Adult Female – NOT of Childbearing Potential  
 Adult Female – Childbearing Potential  
 Adult Male  
 Female Child – Not of Childbearing Potential  
 Female Child – Childbearing 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 # \_\_\_\_\_

### TAPE PRESCRIPTION HERE PRIOR TO FAXING REFERRAL, OR COMPLETE THE FOLLOWING:

**Recommended Starting Dose:** See below for dosage

**Myelodysplastic Syndromes:** The recommended starting dose of REVLIMID® is 10 mg/day with water. Dosing is continued or modified based upon clinical and laboratory findings.

**Multiple Myeloma:** The recommended starting dose of REVLIMID® is 25 mg/day orally for Days 1 – 21 of repeated 28-day cycles. Dosing is continued or modified based upon clinical and laboratory findings

#### REVLIMID®

Dose	Quantity	Directions
<input type="checkbox"/> 5 mg	_____	_____
<input type="checkbox"/> 10 mg	_____	_____
<input type="checkbox"/> 15 mg	_____	_____
<input type="checkbox"/> 25 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 my pharmacy)

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**IMPORTANT INFORMATION ABOUT RevAssist®**

- To avoid fetal exposure, REVLIMID® (lenalidomide) is only available under a special restricted distribution program called “RevAssist®”
  - Only prescribers registered with RevAssist® can prescribe REVLIMID® (lenalidomide)
  - Only RevAssist® contract pharmacies can dispense REVLIMID® (lenalidomide)
  - In order to receive REVLIMID® (lenalidomide), patients must enroll in RevAssist® and agree to comply with the requirements of the RevAssist® program
  - Information about REVLIMID® (lenalidomide) and the RevAssist® program can be obtained by calling the Celgene Customer Care Center toll-free at 1-888-423-5436, or at [www.REVLIMID.com](http://www.REVLIMID.com)
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## ***How to Fill a REVLIMID® (lenalidomide) Prescription***

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1. Healthcare provider (HCP) instructs patient to complete patient survey
2. HCP completes survey
3. HCP completes patient prescription form
4. HCP obtains RevAssist® authorization number
5. HCP provides authorization number on patient prescription form
6. **HCP faxes form, including prescription, to one of the Celgene Pharmacy Network participants (see below)**
7. HCP advises patient that a representative from the pharmacy will contact them
8. Pharmacy conducts patient education
9. Pharmacy calls for confirmation number
10. Pharmacy ships REVLIMID® to patient with the FDA-approved MEDICATION GUIDE

***Please see [www.Celgene.com/PharmacyNetwork](http://www.Celgene.com/PharmacyNetwork) for the list of pharmacy participants***



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