

REVLIMID® (lenalidomide) **Patient Prescription Form** **ATTN:** _____

General Information

Patient Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____
 Work Phone: _____
 Cell Phone: _____
 Soc. Sec #: _____ - _____ - _____ Date of Birth: _____
 Allergies: _____
 Weight: _____ Height: _____ Sex: Male Female

Physician Name: _____
 Practice Name/Hospital: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____
 Fax: _____
 State Lic #: _____ DEA #: _____
 NPI #: _____
 Nurse/Key Office Contact: _____

Insurance Information

Primary Insurance: _____
 Ins. Phone: _____
 Employer: _____

Cardholder Name: _____
 ID#: _____ Group#: _____

Secondary Insurance: _____
 ID#: _____ Group#: _____
 Phone: _____

I consent to have my medical information shared with Patient Support SolutionsSM (PSSSM) for reimbursement purposes. My consent is valid for a period no longer than 12 months from today's date and can be revoked at any time by contacting PSSSM at 1-888-423-5436.

Patient Signature: _____ **Date:** _____

Statement of Medical Necessity

Patient Type From PPAF (Check One)

Primary Diagnosis: _____

 ICD 9 Code: _____

- Adult Female – NOT of Childbearing Potential
- Adult Female – Childbearing Potential
- Female Child – NOT of Childbearing Potential
- Female Child – Childbearing Potential
- Adult Male Male Child

Prescription Information (Tape Prescription Prior to Faxing or Complete Form Below)

Revlimid®

- 5 mg Quantity: _____
- 10 mg Quantity: _____
- 15 mg Quantity: _____
- 25 mg Quantity: _____

Directions: _____
 Directions: _____
 Directions: _____
 Directions: _____

Recommended Starting Dose: See below for dosage
 Dispense as Written Substitution Permitted

NO REFILLS ALLOWED (Maximum Quantity = 28 days)

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

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

Physician Signature: _____ **Date:** _____

Authorization # (To be filled in by healthcare provider) _____ **Date:** _____

Pharmacy Confirmation # (To be filled in by pharmacy) _____ **Date:** _____

*For further information on REVLIMID®, please refer to the full Prescribing Information.

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