



SPECIALTY PHARMACY

CELGENE

Irvine, CA toll free 855.313.9202 toll free fax 844.888.4157

krogerspecialtypharmacy.com

DATE: _____ NEEDS BY DATE: _____ SHIP TO: PATIENT OFFICE OTHER _____

PATIENT INFO	
Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female

PRESCRIBER INFO		
Prescriber Name		
DEA #	NPI #	License #
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

PLEASE FAX COPY OF: PRESCRIPTION CARD FRONT & BACK CLINICAL NOTES MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: _____ (ICD-10): _____

Drug Allergies: _____

Please Attach Supporting Labs and Provide Medication List

PRESCRIPTION INFORMATION

<input type="checkbox"/> Thalomid® <input type="checkbox"/> 50mg <input type="checkbox"/> 100mg <input type="checkbox"/> 150mg <input type="checkbox"/> 200mg Sig: Supplied in blister packs of 28 caps <input type="checkbox"/> Take 1 cap PO daily Qty: 28 No Refills <input type="checkbox"/> _____ Qty: _____ No Refills	Indicate Type From PPAF (Check one) <input type="checkbox"/> Adult Female - Reproductive Potential (FRP) <input type="checkbox"/> Adult Female - NOT of Reproductive Potential (FNRP) <input type="checkbox"/> Adult Male <hr/> <input type="checkbox"/> Female Child - Reproductive Potential (FRP) <input type="checkbox"/> Female Child - NOT of Reproductive Potential (FNRP) <input type="checkbox"/> Male Child Authorization #: Date: _____ <i>(To be filled in by <u>healthcare provider</u>)</i> <i>Authorization # is only valid for 30 days (7 days for FRP)</i> <hr/> Confirmation #: Date: _____ <i>(To be filled in by <u>pharmacy</u>)</i>
<input type="checkbox"/> Pomalyst® <input type="checkbox"/> 1mg <input type="checkbox"/> 2mg <input type="checkbox"/> 3mg <input type="checkbox"/> 4mg Sig: <input type="checkbox"/> Take 1 cap PO daily, days 1-21 of 28 day cycle Qty: 21 No Refills <input type="checkbox"/> _____ Qty: _____ No Refills	
<input type="checkbox"/> Revlimid® <input type="checkbox"/> 2.5mg <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg <input type="checkbox"/> 15mg <input type="checkbox"/> 20mg <input type="checkbox"/> 25mg Sig: <input type="checkbox"/> Take 1 cap PO daily Qty: 28 No Refills <input type="checkbox"/> Take 1 cap PO daily, days 1-21 of 28 day cycle Qty: 21 No Refills <input type="checkbox"/> _____ Qty: _____ No Refills	
<input type="checkbox"/> Ninlaro® <input type="checkbox"/> 4mg <input type="checkbox"/> 3mg <input type="checkbox"/> 2.3mg Sig: Take 1 cap PO once a week, on the same day each week for the first 3 weeks of each cycle Take 1 hour before or 2 hours after food Qty: 3 _____ Refills	

Other:

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Substitution Permitted Date Prescriber's Signature (no stamps) Dispense As Written Date

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