SPECIALTY PHARMACY

CELGENE

Lake Mary, FL toll free toll free fax
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 ❏ Male ❏ 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

❏ Thalomid® ❏ 50mg ❏ 100mg ❏ 150mg ❏ 200mg
Sig: Supplied in blister packs of 28 caps
❏ Take 1 cap PO daily Qty: 28 No Refills
❏ ______________________________ Qty: ______ No Refills

❏ Pomalyst® ❏ 1mg ❏ 2mg ❏ 3mg ❏ 4mg
Sig:
❏ Take 1 cap PO daily, days 1-21 of 28 day cycle Qty: 21 No Refills
❏ ______________________________ Qty: ______ No Refills

❏ Revlimid® ❏ 2.5mg ❏ 5mg ❏ 10mg ❏ 15mg ❏ 20mg ❏ 25mg
Sig:
❏ Take 1 cap PO daily Qty: 28 No Refills
❏ Take 1 cap PO daily, days 1-21 of 28 day cycle Qty: 21 No Refills
❏ ______________________________ Qty: ______ No Refills

❏ Ninlaro® ❏ 4mg ❏ 3mg ❏ 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

Indicate Type From PPAF (Check one)
❏ Adult Female - Reproductive Potential (FRP)
❏ Adult Female - NOT of Reproductive Potential (FNRP)
❏ Adult Male

❏ Female Child - Reproductive Potential (FRP)
❏ Female Child - NOT of Reproductive Potential (FNRP)
❏ Male Child

Authorization #:
Date:
(To be filled in by healthcare provider)
Authorization # is only valid for 30 days (7 days for FRP)

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

❏ Dexamethasone Qty: ______ ______ Refills
Sig:

❏ ______________________ Qty: ______ ______ Refills
Sig:

❏ 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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