Kroger specialty pharmacy

Celgene REMS

Lake Mary, FL **toll free** **toll free fax** **krogerspecialtypharmacy.com**

Date: __________ Need By Date: __________ Ship To: ☐ Patient ☐ Office ☐ Other ________________ Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back

Patient Information

Patient Name	
Address	
City State Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	☐ Male ☐ Female

Prescriber Information

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

Clinical Information

Diagnosis	ICD-10
Drug Allergies	

Please Attach Supporting Labs and Provide Medication List

Prescription Information

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 # *(to be filled in by healthcare provider; Authorization # is only valid for 30 days; 7 days for FRP)*	Date
Confirmation # *(to be filled in by pharmacy)*	Date

Med	Dose/Strength	Directions	Qty	Refills
☐ Pomalyst®	☐ 1mg ☐ 2mg ☐ 3mg ☐ 4mg	☐ Take 1 cap PO daily, days 1-21 of 28 day cycle ☐ ____________	21 ______	No Refills No Refills
☐ Revlimid®	☐ 2.5mg ☐ 5mg ☐ 10mg ☐ 15mg ☐ 20mg ☐ 25mg	☐ Take 1 cap PO daily ☐ Take 1 cap PO daily, days 1-21 of 28 day cycle ☐ ____________	28 21 ______	No Refills No Refills No Refills
☐ Thalomid® *Supplied in blister packs of 28 caps*	☐ 50mg ☐ 100mg ☐ 150mg ☐ 200mg	☐ Take 1 cap PO daily ☐ ____________	28 ______	No Refills No Refills
Supportive Therapies				
☐ Dexamethasone	☐ 2mg ☐ 4mg	☐ Take ________ mg PO once weekly on days 1, 8, 15 and 22 of a 28 day cycle ☐ ____________	28 Day Supply ______	______ ______
☐ Hemady®	20mg	☐ Take ________ mg PO once weekly on days 1, 8, 15 and 22 of a 28 day cycle ☐ ____________	28 Day Supply ______	______ ______
☐ Ninlaro®	☐ 2.3mg ☐ 3mg ☐ 4mg	☐ Take 1 cap PO weekly on days 1, 8, and 15 of a 28 day cycle ☐ ____________	3 ______	______ ______
☐ 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. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Prescriber's Signature (no stamps) Substitution Permitted ____________ Date ____________

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