CenterWell Specialty Pharmacy

Fax: 877-405-7940
Phone: 800-486-2668
Monday – Friday: 8 a.m. – 11 p.m., and
Saturday: 8 a.m. – 6:30 p.m., Eastern time

Oncology REMS Prescription Form

Patient information

Patient: _____ ❒ Female ❒ Male DOB: _____ Insurance plan: _____ Plan ID #: _____

Address: _____ City: _____ State: _____ ZIP code: _____

Home phone #: _____ Cell phone #: _____ Caregiver: _____ Caregiver phone #: _____

Other medical conditions: _____ Allergies: ❒ No ❒ Yes: _____

Height: _____ Weight: _____ ❒ lb ❒ kg Date: _____

Clinical information

Need by date: _____ BSA: _____m^2

ICD-10 code(s): _____ Diagnosis: _____ Diagnosis date: _____

Concurrent medications: _____

Renal dysfunction: ❒ No ❒ Yes Current SCr: _____ or current GFR: _____mL/min

Liver dysfunction: ❒ No ❒ Yes Abnormal lab values: _____

REMS information

Authorization #: _____
Date obtained: _____

Patient type:
❒ Adult female: Childbearing potential
❒ Adult female: **No** childbearing potential
❒ Adult male
❒ Child female: Childbearing potential
❒ Child female: **No** childbearing potential
❒ Child male

Prescription information

Note: Ohio law allows one prescription per preprinted order form. Please use additional forms for more than one prescription.

Medication	Strength	Directions	Quantity	Refills
❒ Pomalyst capsules (pomalidomide)	❒ 1 mg ❒ 2 mg ❒ 3 mg ❒ 4 mg	❒ Take one capsule daily for 21 days followed by 7 days off. ❒ Other: _____	_____	N/A
❒ Revlimid capsules (lenalidomide)	❒ 2.5 mg ❒ 5 mg ❒ 10 mg	❒ Take one capsule daily. ❒ Take one capsule daily for 21 days followed by 7 days off. ❒ Other: _____	_____	N/A
	❒ 15 mg ❒ 20 mg ❒ 25 mg	❒ Take one capsule daily for 21 days followed by 7 days off. ❒ Other: _____	_____	
❒ Thalomid capsules (thalidomide)	❒50 mg ❒100 mg ❒150 mg ❒200 mg	❒ Take one capsule daily. ❒ Other: _____	❒ 28 ❒ 56 ❒ 84 ❒ _____	N/A
❒ Other: _____	_____	_____ _____	_____	_____
❒ Other: _____	_____	_____ _____	_____	_____
❒ Other: _____	_____	_____ _____	_____	_____

Prescriber and shipping information (please print)

Prescriber: _____ NPI: _____

Ship to: ❒ Patient ❒ Office ❒ Other: _____

Office address: _____ City: _____ State: _____ ZIP code: _____

Office phone number: _____ Office fax number: _____

Signature: _____ Date: _____

We will dispense this prescription as generic, unless the prescriber indicates "Dispense as Written" here: _____

The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form and fax language. Noncompliance with state-specific requirements could result in outreach to the prescriber.