US Bioservices
AmerisourceBergen

Revlimid / Thalomid / Pomalyst Referral Form

Phone: (877) 757-0667
Fax: (888) 899-0067

Deliver to: ☐ Patient's Home ☐ Prescriber's Office ☐ Other: _____ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date: _____

1. Patient Information

Last Name: _____ Home Phone: _____ Work / Mobile Phone: _____

First Name: _____ Home Address: _____

S.S. #: _____ Date of Birth: _____ City: _____ State: _____ Zip: _____

Guardian / Caregiver: _____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____ ☐ lb ☐ kg

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription and medical)

Medical Insurance: _____ Phone: _____ Prescription Card: _____ Phone: _____

Subscriber Name: _____ Policy #: _____ BIN / PCN: _____

Policy #: _____ Group #: _____ Medicare #: _____ Medicaid #: _____

3. Prescriber Information

Prescriber Name: _____ ☐ MD ☐ DO ☐ NP ☐ PA License #: _____ NPI #: _____ DEA #: _____

Practice Name: _____ Phone: _____ Fax: _____

Address: _____ Office Contact: _____ Phone: _____

City: _____ State: _____ Zip: _____ Collaborating Physician: _____

4. Diagnosis and Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Primary ICD-10: _____ Meds Tried / Failed: _____

Secondary ICD-10: _____

Allergies: _____ Concurrent Medications: _____

Vaccination History: _____

5. Prescription Information

Medication	Dose / Strength	Strength / Directions (SIG)	
☐ **REVLIMID®** (lenalidomide)	☐ 2.5 mg ☐ 5 mg ☐ 10 mg ☐ 15 mg ☐ 20 mg ☐ 25 mg	Directions: _____ Qty: _____	Rest Period: _____ Authorization Number: _____ Date: _____
☐ **THALOMID®** (thalidomide)	☐ 50 mg ☐ 100 mg ☐ 150 mg ☐ 200 mg	Directions: _____ Qty: _____	Rest Period: _____ Authorization Number: _____ Date: _____
☐ **POMALYST®** (pomalidomide)	☐ 1 mg ☐ 2 mg ☐ 3 mg ☐ 4 mg	Directions: _____ Qty: _____	Rest Period: _____ Authorization Number: _____ Date: _____
☐ **DEXAMETHASONE**	☐ 4 mg	Directions: _____	Rest Period: _____ Date: _____ Qty: _____

Patient Type From PPAF

☐ Adult Female - NOT of Reproductive Potential ☐ Adult Female - Reproductive Potential ☐ Adult Male
☐ Female Child - NOT of Reproductive Potential ☐ Female Child - Reproductive Potential ☐ Male Child

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted patient support program.

Patient Signature _____ Date ____ / ____ / ____

Account Manager _____

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize US Bioservices Corporation to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible _____ PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date ____ / ____ / ____

Prescriber Signature-Dispense as Written _____ PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date ____ / ____ / ____