OncoMed
The Oncology Pharmacy

MVP® HEALTH CARE

pharmacy 877.662.6633
fax 877.662.6355

Revlimid® - Thalomid® Oral Oncology Rx Order Form

Patient Information

Date: ______________

Patient Name:________________________________ Date of Birth: _________ Sex: ☐ M ☐ F

Address: ________________________________ City: ___________________________ State: _______________ Zip: ___________

Home Ph: _________________ Work Ph: _________________ Cell Ph: _________________ email: ______________________

May we contact patient regarding co-pays & insurance questions? ☐ **Yes** ☐ **No**

Insurance Information (Medical Benefit)

Primary: _________________________

MVP Subscriber Name: _________________________ MVP Member #:___________________________Ph: ______________________

Address: ______________________________ City: ___________________________ State: _______________ Zip: _______________

Secondary: ______________________ Policy Holder: ___________________ Policy #:_____________ Ph: ______________________

Address: ______________________________ City: ___________________________ State: _______________ Zip: _______________

Prior Therapy Type : ☐ **Velcade** ☐ **Alkeran** ☐ **Thalomid** ☐ **Other** ______________________________________

Clinical/Prescription information

☐ **Revlimid® - RevAssist**
☐ **Thalomid® - STEPS Program**

Physician Authorization#: ________________________ Date:______
Pharmacy Confirmation#:________________________ Date:______

Revlimid Patient Type

☐ Adult Female - Childbearing Potential
☐ Adult Female - **NOT** of Childbearing Potential
☐ Child Female - Childbearing Potential
☐ Child Female - **NOT** Childbearing Potential
☐ Adult Male
☐ Child Male

Rx Prescription

Oral Medication	Available Strengths (please check)				Directions	Quantity	Blister Pac
Revlimid®	☐ 5mg	☐ 10mg	☐ 15mg	☐ 25mg			☐ yes ☐ no
Dexamethasone	☐ 4mg						☐ yes ☐ no
Asprin (enteric-coated)	☐ 81mg	☐ 325mg					☐ yes ☐ no
Thalomid®	☐ 50mg	☐ 100mg	☐ 150mg	☐ 200mg			
Dexamethasone	☐ 4mg						☐ yes ☐ no

Celgene Patient Assistance (Revlimid®/Thalomid®): I consent to have my medical information shared with Patient Support Solutions™(PSS™) for reimbursement purposes. Consent is valid for a period no longer than 12 months from today's date can be revoked at any time by contacting PSS™ at 1.888.423.5436.
Patient Signature:____ **Date:**____________

Diagnosis Information

Primary Dx: ______________________________

Stage: ____________________ ICD-9: _________

Secondary Dx: ____________________________

ICD-9: __________________________________

Patient Weight: _______ lbs Patient Height: ______

BSA: ____________________________________

Allergies: ________________________________

Physician Information

Physician Name:____

Contact: ________________________ email: ____________________ _____

Street: ____

City: ___________________________ State: __________ Zip: _________

Ph: _________________________ Fax: ___________________________

State License #: ____________ DEA #: ____________ NPI #: __________

Prescriber Signature (required by law) __________________________________

Shipping Instructions

☐ Deliver to Patient

Date Required: ___________________________ Preferred Delivery Time: _______________________ ☐ AM ☐ PM

Oral prescriptions will be billed through patient's PBM provider.