AcariaHealth
Specialty Pharmacy

Phone: 866.458.9246 • Fax: 866.458.9245

Date Shipment Needed: _____ Ship To: ❑Patient ❑Prescriber
❑Nursing needed ❑Training needed ► All the supplies including syringes and needles will be dispensed if needed.

REVLIMID REFERRAL FORM

PATIENT INFORMATION

Patient Name:	DOB:	Sex: ❑M ❑F ❑Other:	Weight:	❑lbs. ❑kg.
Address:	City:	State:	Zip:	
Phone:	Allergies:			
Alternate Contact:	Phone:	❑**Additional Demographic Information Attached**		

PRESCRIBER INFORMATION

Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:	Practice Name:		
Address:	City:	State:	Zip:
Phone: Fax:	Key Office Contact:	Phone:	

INSURANCE INFORMATION

❑**Please attach front and back of patient's insurance card (medical and prescription).**

COPAY CARD ENROLLMENT

❑**Patient authorizes AcariaHealth to be contacted for financial assistance.** **Patient's Signature:**

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

Primary Diagnosis: (ICD-10 Code & Description) _____

- Has patient been treated *previously* for this condition? ❑Yes ❑No Medication(s): _____
- Is patient *currently* on therapy? ❑Yes ❑No Medication(s): _____
- Will patient stop taking the above medication(s) before starting the new medication? ❑Yes ❑No If yes: _____
- How long should patient wait before starting the new medication? _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____

RISK CATEGORY

❑ Adult Female – NOT of Reproductive Potential
❑ Adult Female – Reproductive Potential
❑ Adult Male
❑ Female Child – NOT of Reproductive Potential
❑ Female Child – Reproductive Potential
❑ Male Child

PRESCRIPTION INFORMATION

REVLIMID® ❑ 2.5 mg capsule ❑ 5 mg capsule ❑ 10 mg capsule
❑ 15 mg capsule ❑ 20 mg capsule ❑ 25 mg capsule

QTY: ____# capsules (MAX QTY x 28 DAYS) NO REFILLS ALLOWED

Instructions:

❑ Take one capsule by mouth once daily x 14 days, then take 7 days off
❑ Take one capsule by mouth once daily x 21 days, then take 7 days off
❑ Other: _____

Authorization #_____ Confirmation #_____

Prescriber's Signature: _____ ❑ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription electronically or on official state prescription blank. Prescriber authorizes AcariaHealth to forward this prescription to another pharmacy, if needed.