

Phone: 866.458.9246 • Fax: 866.458.9245

THALOMID REFERRAL FORM

PATIENT INFORMATION			
Patient Name:	DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other:	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg.
Address:		City:	State: Zip:
Phone:	Allergies:		
Alternate Contact:	Phone:	<input type="checkbox"/> 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			
<input type="checkbox"/> Please attach front and back of patient's insurance card (medical and prescription).			
COPAY CARD ENROLLMENT			
<input type="checkbox"/> Patient authorizes AcariaHealth to be contacted for financial assistance.		Patient's Signature: _____	
DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT			
Primary Diagnosis: (ICD-10 Code & Description) _____			
<ul style="list-style-type: none"> ▪ Has patient been treated <i>previously</i> for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): _____ ▪ Is patient <i>currently</i> on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): _____ ▪ Will patient stop taking the above medication(s) before starting the new medication? <input type="checkbox"/> Yes <input type="checkbox"/> 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			
<input type="checkbox"/> Adult Female – NOT of Reproductive Potential <input type="checkbox"/> Adult Female – Reproductive Potential <input type="checkbox"/> Adult Male <input type="checkbox"/> Female Child – NOT of Reproductive Potential <input type="checkbox"/> Female Child – Reproductive Potential <input type="checkbox"/> Male Child			
PRESCRIPTION INFORMATION			
THALOMID® <input type="checkbox"/> 50 mg capsule <input type="checkbox"/> 100 mg capsule <input type="checkbox"/> 150 mg capsule <input type="checkbox"/> 200 mg capsule			
Instructions:			QTY: _____ # capsules NO REFILLS (MAX QTY x 28 DAYS) ALLOWED
<input type="checkbox"/> Take one capsule by mouth once daily x 28 days <input type="checkbox"/> 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.

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. 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 by mistake, then destroy this document. Please direct all verification or notification to AcariaHealth or any of its subsidiaries using the contact information provided on this coversheet.