Celgene Prescription Referral Form

Carepoint Pharmacy
Phone: 732-885-1000 **Fax: 732-980-0357**
10 Plainfield Ave., Suite 1, Piscataway, New Jersey 08854 www.carepointpharmacynj.com

Complete Patient Demographic Information in Section Below OR Attach Face Sheet from Patient Chart			
First Name :	*Middle Initial :*	*Last Name :*	
Date of Birth :	*Gender:* ◯ M ◯ F	*SSN :*	
Street Address :	*City :*	*State :*	*Zip Code :*
Home Phone :	*Work Phone :*	*Cell Phone :*	

Complete Patient Insurance Information in Section Below OR Attach Copies of Patient Insurance Card			
Insurance Carrier Name - Primary :	*Name of Insured :*		*Relationship :*
ID# :	*Group # :*		*Insurance Phone :*
Rx Carrier Name - Secondary :	*Rx ID# :*	*Rx Group #:*	*Rx Phone # :*

Complete Drug Therapy Information in Section Below OR Attach Completed Prescription	
Drug Name	Form/Strength/Directions for Use
☐ **Pomalyst**	◯ 1mg ◯ 2mg ◯ 3mg ◯ 4mg Directions _____ Qty _____ Rest Period _____ Auth number _____ Date _____ Confirmation _____ Date _____
☐ **Revlimid**	◯ 5mg ◯ 10mg ◯ 15mg ◯ 21mg Directions _____ Qty _____ Rest Period _____ Auth number _____ Date _____ Confirmation _____ Date _____
☐ **Thalomid**	◯ 50mg ◯ 100mg ◯ 150mg ◯ 200mg Directions _____ Qty _____ Rest Period _____ Auth number _____ Date _____ Confirmation _____ Date _____
	Risk Category ☐ Adult Female, NOT of Reproductive Potential ☐ Adult Female, Reproductive Potential ☐ Adult Male ☐ Male Child ☐ Female Child, NOT of Reproductive Potential ☐ Female Child, Reproductive Potential

Clinical Data			
Primary Diagnosis:	ICD - 10 :	*Weight :*	*Height :*
Allergies :			
Failed Therapies :			
Please provide Current list of medications:			

Complete Prescriber Information in Section Below NOT Included on Attached Prescription				
MD First Name :	*MD Last Name :*		*DEA # :*	
UPIN :	*State License # :*	*NPI :*		
Office Address :		*City :*	*State :*	*Zip Code :*
Office Phone:		*Office Fax :*		*Office Contact Name :*
Office Contact Name:		*Office Email:*		

SIGNATURE OF LICENSED PRESCRIBER IS REQUIRED TO VALIDATE PRESCRIPTIONS	
☐ *I authorize Carepoint Pharmacy to initiate a Prior Authorization on my behalf.*	**Date :**
Dr : Substitution Permitted	**Dr :** No Substitution Permitted