Ph: 877.662.6633 • Fax: 877.662.6355 • E-Prescribe: Oncomed Dba Onco360 or NPI # 1679618151

Multiple Myeloma Prescription Form

PATIENT INFORMATION You may also fax demographics/face sheet

Patient Name:________________________ DOB: __________
SSN: ________________________
Address: ________________________
City, State, Zip: ________________________
Home Phone: ____________ Cell Phone: ____________
Known Allergies: ________________________
Height: ________ Weight: ______ lbs. ☐ M ☐ F
Emergency Contact: ________________________
Emergency Contact Phone: ________________________

INSURANCE INFO. Please fax copy of ALL insurance cards *front & back

Primary Insurance: ________________________
Policy Number: ____________ Group Number: ____________
Rx Bin: ____________ Rx PCN: ____________
Secondary Insurance: ________________________
Policy Number: ____________ Group Number: ____________
Rx Bin: ____________ Rx PCN: ____________

PRESCRIBER INFORMATION

Prescriber Name: ________________________ NPI#: ____________ DEA#: ____________ TAX ID: ____________
Address: ________________________ City, State, Zip: ________________________
Office Contact: ________________________ Phone: ____________ Fax: ____________

DIAGNOSIS INFORMATION Please fax recent labs, clinical notes, etc. to help expedite the prior authorization process

Primary Diagnoses: ________________________ Primary ICD-10: ____________ Secondary ICD-10: ____________
Prior Therapies: ________________________ Reasons for Discontinuation: ________________________
Prior Therapies: ________________________ Reasons for Discontinuation: ________________________
Comorbidities: ________________________ Known Allergies: ________________________

CLINICAL/PRESCRIPTION INFORMATION

☐ **RevlimidREMS™** ☐ **ThalomidREMS™** ☐ **PomalystREMS™**
Prescriber Authorization #: ____________ Date: ____________
Pharmacy Confirmation #: ____________ Date: ____________

PATIENT 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

RX PRESCRIPTION

MEDICATION	DOSE/STRENGTH	SIG	QTY	REFILLS	BLISTER PACK
☐ **Elrexfio™** (elranatamab-bcmm) subcutaneous injection	☐ 44 mg/1.1 mL single dose vial ☐ 76 mg/1.9 mL single dose vial	☐ Inject 76 mg subcutaneously weekly ☐ Inject 76 mg subcutaneously every two weeks ☐ Other: Inject _____mg subcutaneously every ___________			
☐ **Revlimid®** (Lenalidomide) capsules	☐ 2.5 mg ☐ 5 mg ☐ 10 mg ☐ 15 mg ☐ 20 mg ☐ 25 mg	☐ Take _____mg orally once daily for ____ days followed by ____ days off ☐ Take _____mg orally once daily ☐ Other: ____________		0	☐ Yes ☐ No
☐ **Pomalyst®** (pomalidomide) capsules	☐ 1 mg ☐ 2 mg ☐ 3 mg ☐ 4 mg	☐ Take _____mg orally once daily for ____ days followed by ____ days off ☐ Other: ____________		0	☐ Yes ☐ No
☐ **Thalomid®** (thalidomide) capsules	☐ 50 mg ☐ 100 mg ☐ 150 mg ☐ 200 mg	☐ Take _____mg orally once daily for ____ days followed by ____ days off ☐ Take _____mg orally once daily ☐ Other: ____________		0	
☐ **Dexamethasone** tablets	☐ 0.5 mg ☐ 0.75 mg ☐ 1 mg ☐ 1.5 mg ☐ 2 mg ☐ 4 mg ☐ 6 mg	☐ Take _____mg orally once weekly ☐ Other: ____________			☐ Yes ☐ No
☐ **Ninlaro®** (ixazomib) capsules	☐ 2.3 mg ☐ 3 mg ☐ 4 mg	☐ Take _____mg orally once weekly on days 1, 8, 15, of each 28-day cycle ☐ Other: ____________			
☐ **Xpovio®** (selinexor) tablets	☐ 20 mg ☐ 40 mg ☐ 50 mg ☐ 60 mg	☐ Take _____mg orally twice weekly ☐ Take _____mg orally once weekly ☐ Other: ____________			
☐ **Melphalan** tablets	☐ 2 mg	☐ Take _____mg orally once daily on days 1-4 every 6 weeks ☐ Other: ____________			
☐ **Cyclophosphamide**	☐ 25 mg tablets ☐ 50 mg tablets ☐ 25 mg capsules ☐ 50 mg capsules	☐ Take _____mg orally on days 1, 8, 15, 22 of each 28-day cycle ☐ Other: ____________			

DELIVERY INFORMATION

Need by: ____________ **Deliver to:** ☐ Patient's home ☐ MD Office/ Clinic ☐ Other: ____________

PRESCRIBER'S SIGNATURE REQUIRED

MD | NP | PA Signature: ________________________ ☐ **DAW** **Date:** ____________

*Signature on this form also provides consent to contact this patient's insurance provider for this prescription on the provider's behalf.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.