ACS Advanced Care Scripts
Omnicare Specialty Care Group

Celgene Therapy Referral Form

Phone: 877-985-MEDS(6337) Fax: 866-679-7131

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 *(circle one)* Directions: ____ | Qty: ____ | Rest period: ____ Auth number: ____ | Date: ____ Confirmation: ____ | Date: ____
☐ **Revlimid**	5mg | 10mg | 15mg | 25mg *(circle one)* Directions: ____ | Qty: ____ | Rest period: ____ Auth number: ____ | Date: ____ Confirmation: ____ | Date: ____
☐ **Thalomid**	50mg | 100mg | 150mg | 200mg *(circle one)* Directions: ____ | Qty: ____ 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:* pounds	*Height:* inches
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 E-mail:*	

SIGNATURE OF LICENSED PRESCRIBER IS REQUIRED TO VALIDATE PRESCRIPTIONS

☐ *I authorize Advanced Care Scripts to initiate a Prior Authorization on my behalf.* *TLC9-15-15*

Dr:	**Dr:**	**Date:**
Substitution Permitted	***No Substitution Permitted***	