



PRESCRIBER REGISTRATION FORM

Welcome to RevAidSM. RevAidSM is a Health Canada–mandated controlled distribution program designed to ensure that all necessary steps are taken by REVLIMID[®] (lenalidomide) prescribers, patients and pharmacies to prevent fetal exposure.

RevAidSM OVERVIEW:

- Only prescribers registered in the program can enroll patients and prescribe REVLIMID[®].
- Patients must be enrolled and comply with the program requirements to be eligible to receive REVLIMID[®].
- Only pharmacies registered with RevAidSM can dispense REVLIMID[®].

For more information about RevAidSM call 1-888-RevAid1 (1-888-738-2431) or visit www.RevAid.ca.

Registered prescribers must commit to the following:

- Provide patient counselling on the benefits and risks of REVLIMID[®] therapy, including Boxed Warnings.
- Ensure females of childbearing potential have a consultation with a qualified physician experienced in the use of contraceptive methods to discuss the best two simultaneous effective contraceptive methods to be used. The discussion must take into account:
 - The cumulative risks of deep venous thrombosis including, but not limited to, REVLIMID, cancer, and hormonal contraception.
 - The compliance issue.
 - The risk of possible contraception failure.
 - The potential need of emergency contraception.
 - The risk of birth defects or fetal death should a pregnancy occur, and provide related educational materials.

- Schedule pregnancy testing for females of childbearing potential. Pregnancy testing should be medically supervised.
- Inform **All Male Patients** to use a condom during any sexual contact with females of childbearing potential (even if they have had a vasectomy).
- Enroll patients using the RevAidSM Patient-Physician Agreement Form.
- Comply with survey requirements and remind patients to complete mandatory surveys.
- Survey requirements:
 - For females of childbearing potential, physicians and patients must complete a survey at the time of each prescription, indicating her understanding of the need to use two simultaneous contraceptive methods during treatment (while taking REVLIMID, during dose interruptions, and for 4 weeks after the discontinuation of dosing).
 - For patients not of childbearing potential, physicians must complete a biannual survey to be in good standing, and individual patients must complete a survey every 84 days.
- Prescribe no more than the allowable amount—maximum of 28 days supply for female of childbearing potential, and maximum of 84 days supply for patients not of childbearing potential.
- Prescriptions must be filled within 7 days of the negative pregnancy test for females of childbearing potential or within 14 days of the prescription for other patients.
- Write your RevAidSM unique prescriber ID number on every REVLIMID[®] prescription.
- Inform the program immediately if a patient or their partner becomes pregnant and complete the required pregnancy reporting forms (INITIAL PREGNANCY REPORT FORM, PREGNANCY FOLLOW-UP AND OUTCOME FORM, and INFANT FOLLOW-UP FORM, as required).
- Return to RevAidSM all REVLIMID[®] that is returned by patients. Call a RevAidSM representative at 1-888-RevAid1 (1-888-738-2431) to arrange for returns.

TO BECOME A REGISTERED REVLIMID[®] PRESCRIBER, PLEASE COMPLETE THE SECTION BELOW AND FAX/MAIL TO THE RevAidSM PROGRAM:

Prescriber Name: _____ (LAST) _____ (FIRST)

Lic. No.: _____ Province: _____ Specialty: _____

Primary Contact Information:

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: _____ - _____ - _____ Fax: _____ - _____ - _____ Email address: _____

Name of primary contact (if other than prescriber) _____

I understand that if I fail to comply with all requirements of the RevAidSM program, dispensing of my prescriptions for REVLIMID[®] will be delayed until all requirements have been met. I hereby consent to the collection of the information on this form as it pertains to me by McKesson Canada to administer this program. I further consent to the disclosure of this information to Celgene and McKesson Canada for the purposes of reporting requirements, program monitoring, evaluation, and educational and training purposes. In addition, I am aware that relevant de-identified data may also be shared with payers where necessary for reimbursement purposes.

Prescriber Signature _____ Date: _____ (DD/MM/YY)

Incomplete information will result in delay. Please call with questions: 1-888-RevAid1 (1-888-738-2431)
Return signed copy to RevAidSM. Fax: 1-877-585-2382 or Mail: 169 The Donway West, P.O. Box 383, Don Mills, ON M3C 2S7



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