REBLOZYL® AUTHORIZATION TO INJECT
BETA(β)-THALASSEMIA

Patient Support Program for REBLOZYL
PLEASE COMPLETE AND FAX TO: 1-833-951-2483
FOR QUESTIONS, PLEASE CALL: 1-833-951-2482

This form should be completed ONLY in one of the following scenarios:

- Per your preference indicated in the Enrolment form
- After a period of 8 dosing cycles (24 weeks)
- Upon a change of dose

The completed form MUST be sent to the Patient Support Program for REBLOZYL at least 3 business days prior to next injection

Program Patient ID: ____________ **Pateint Initials:** ____________

Patient Date of Birth (DD/MONTH/YYYY): ____________

Section 1: Treatment Information

This section is to be completed by the Patient Support Program for REBLOZYL.

Next scheduled injection	Date (DD/MONTH/YYYY):		Time (24HR):
Previous injection	Date (DD/MONTH/YYYY):	Dose level (mg/kg):	Cycle number:
First injection (start date)	Date (DD/MONTH/YYYY):		
Patient weight	**Weight taken from most recent post-injection report** Weight (kg):		Date (DD/MONTH/YYYY):
Physician information	Last name: ____________ First name: ____________ Location: ____________ Pharmacy: ____________		

Section 2: Prescription

This section is to be completed per your preference indicated in the Enrolment form, after a period of 8 dosing cycles (24 weeks), or upon a change of dose.

Patient information

Last name: ____________ First name: ____________

Home address: ____________

City: ____________ Province: ____________ Postal code: ____________

Allergies and/or other medication(s) or relevant medical information: ____________

REBLOZYL (luspatercept for injection) dose level*	☐ 1.25 mg/kg ☐ 1.0 mg/kg ☐ 0.8 mg/kg ☐ 0.6 mg/kg ☐ No dose required (due to hemoglobin level that is: ≥115 g/L and not influenced by recent transfusion).

Prescription valid for a maximum of 8 dosing cycles

Otherwise, please specify: ____________

* REBLOZYL injections are recommended once every 3 weeks by subcutaneous injection. The dosage indicated on this form will be applied for a maximum of 8 cycles, unless otherwise specified. Please see the Product Monograph for complete dosing and administration instructions.

Medical license number:

By signing below, I acknowledge that I am responsible for informing the Patient Support Program for REBLOZYL of any changes to the prescribed REBLOZYL dosing regimen appropriate for this patient after reviewing and assessing the patient's blood tests prior to each injection. In the absence of any reported changes from Physician to Program, such as adjusting the patient dose or discontinuing treatment based on how the patient responds to REBLOZYL, the Program should continue to dose the patient in accordance with my most recent instructions.

Signature of Referring Physician/Hematologist: ____________ Date (DD/MONTH/YYYY): ____________

Patient Support Program for REBLOZYL: **Phone:** 1-833-951-2482 **Fax:** 1-833-951-2483

Reference: REBLOZYL Product Monograph. Celgene Inc.

Patient Support Program
Your patient. Our commitment.

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Pr Reblozyl®
luspatercept for injection