REBLOZYL®
POST-INJECTION REPORT

Patient Support Program for REBLOZYL
FAX: 1-833-951-2483
PHONE: 1-833-951-2482

Injection Date (DD/MONTH/YYYY): _____ **Time** (24HR): _____

Physician Information

Name:	Telephone:	Fax:

Patient Information

Program Patient ID:		Date (DD/MONTH/YYYY):
Last Name:	First Name:	Patient Weight at Today's Injection (kg):

Allergies: ☐ NKA

Injection Clinic Information

Clinic Name:	Clinic Address:

Injection Information

Drug Name:	Dose (mg):

Lot Number(s) and Expiry Date(s):

Route:	Injection Site(s):

Dose Information

Did the patient require a dosage modification? ☐ Yes ☐ No	Reason:
Previous dose (mg/kg):	New dose (mg/kg):

PATIENT'S NEXT INJECTION WILL BE ON:

Date (DD/MONTH/YYYY): _____ **Time** (24HR): _____

☐ **UNKNOWN**

ADVERSE EVENT AND/OR PRODUCT QUALITY COMPLAINT REPORTED: ☐ Yes* ☐ N/A

**If yes, it must be reported SAME DAY of awareness to Manufacturer as per Manufacturer Reporting Requirements (BMS-SOP-1d). Manufacturer: BRISTOL MYERS SQUIBB.*

Date Reported (DD/MONTH/YYYY): _____

CLEAR FORM

Bristol Myers Squibb™
Patient Support Program >
Your patient. Our commitment.

2007-CA-2200039E

Pr Reblozyl®
luspatercept for injection