Treatment Continuation Scheme™ (TCS) | Pregnancy Prevention Programme | Revlimid® Options Scheme (ROS)

Revlimid®▼ (lenalidomide) Prescription Authorisation Form (PAF) - (Dual Format Version 1.1)

A newly completed copy of this form MUST accompany EVERY Revlimid® prescription. Completion of this information is mandatory for ALL patients.
Please complete using BLOCK CAPITALS and BLACK INK. All completed forms (irrespective of the diagnosis) MUST be sent (faxed) to Celgene (Fax 0808 156 3058)

This form must be used for patients enrolled on either the TCS or ROS

Name of treating Hospital

Patient Date of Birth | Patient Initials (first, middle, last)

Prescribing physician (print)

Diagnosis

Is this patient being treated in accordance with NICE guidance for Revlimid®? - Y or N

Is this patient being treated outside of the final NICE guidance for Revlimid®, but eligible for the Revlimid Options Scheme? - Y or N

Capsule strength prescribed: 5 mg | 10 mg | 15 mg | 25 mg

Please enter the cycle number of Revlimid® prescribed for this patient

Please tick all boxes that apply

Woman of non-childbearing potential

Male

The patient has been counselled about the teratogenic risk of treatment with Revlimid® and understands the need to use a condom if involved in sexual activity with a woman of childbearing potential (even if the patient has had a vasectomy).

Note to pharmacist – do not dispense unless ticked

Woman of childbearing potential

The patient has been counselled about the teratogenic risk of treatment and the need to avoid pregnancy, and has been on effective contraception for at least 4 weeks?

Date of last negative pregnancy test

Note to pharmacist – do not dispense unless ticked and a negative test has been conducted within 3 days prior of the prescription date

Date faxed to Celgene | Faxed by (Name)

Both signatures must be present prior to dispensing Revlimid®

Prescriber's declaration

I am a physician experienced in managing haematological malignancy and I have read and understood the Revlimid Healthcare Professional's Information Pack and confirm that the patient has signed an informed consent for Revlimid® treatment.

Sign | Date | Bleep

Print

Note to pharmacist – prescription and Prescription Authorisation Form must have the same date

Pharmacist's declaration

I am satisfied that this Revlimid® Prescription Authorisation Form has been completed fully, confirm that dispensing is taking place within 7 days of the date of prescription and that I have read and understood the Revlimid® Healthcare Professional's Information Pack.

Sign | Date | Bleep

Print

Name and postcode of dispensing pharmacy

REV/502/07-10/07-12 and REV/737/05-11/05-13