IMNOVID®▼ (pomalidomide) Prescription Authorisation Form (PAF)

A newly completed copy of this form MUST accompany EVERY IMNOVID® prescription. Completion of this information is mandatory to ALL patients. The completed form should be retained in pharmacy.

Name of treating Hospital

Patient Date of Birth D D M M Y Y Y Y Patient ID Number/Initials

Prescribing physician: (print)

Diagnosis: (tick) **Multiple Myeloma** ☐ ☐ ☐ ☐

Other ☐ If other please specify usage:

If this patient is being treated privately, tick here ☐

Capsule strength prescribed: (tick)	1mg ☐	2mg ☐	3mg ☐	4mg ☐
Quantity of **Capsules** per cycle prescribed:*				
Number of cycle(s) prescribed 1 ☐ 2 ☐ 3 ☐				

* Do **NOT** enter number of Packs

Total number of capsules to be prescribed:

Please enter the cycle number(s) of IMNOVID® prescribed for this patient

Woman of non-childbearing potential

Male

The patient has been counselled about the teratogenic risk of treatment with IMNOVID®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 (maximum 4 weeks prescription only)

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 D D M M Y Y Y Y

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

E-mail to the completed form to paf.uk.ire@celgene.com or Fax to 0808 100 9910

Both signatures must be present prior to dispensing IMNOVID®

Prescriber's declaration

I am a physician experienced in managing anti-cancer therapies and I have read and understood the IMNOVID® Healthcare Professional's Information Pack and confirm that the patient has signed an informed consent for IMNOVID® treatment.

Sign Date D D M M Y Y Y Y

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Note to pharmacist – prescriptions must be accompanied by a Prescription Authorisation Form

Pharmacist's declaration

I am satisfied that this IMNOVID® Prescription Authorisation Form has been completed fully and that I have read and understood the IMNOVID® Healthcare Professional's Information Pack. For women of child bearing potential, dispensing will take place within 7 days of the days of prescription.

Sign Date D D M M Y Y Y Y

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Name and postcode of dispensing pharmacy

Home delivery information

Name and postcode of Home delivery company used, if applicable.

Date faxed to Celgene D D M M Y Y Y Y Faxed by (Name)