Thalidomide Celgene® Pregnancy Prevention Programme
Prescription Authorisation Form - UK

A newly completed copy of this form MUST accompany every Thalidomide Celgene® prescription. Completion of this form is mandatory for ALL patients and the completed form should be retained in pharmacy for 2 years as it will be required for review during a Thalidomide Celgene® Pregnancy Prevention Programme audit.

Patient Name:	
Hospital Number:	
Date of Birth:	DD MM YYYY
Prescriber Name:	
Diagnosis:	

Please tick in the box next to the appropriate patient category, and enter the additional information requested for male and women of childbearing potential patients.

☐ Woman of non-childbearing potential

☐ Male

The patient has been counselled about the teratogenic risk of treatment with Thalidomide Celgene® and understands the need to use a condom if involved in sexual activity with a woman of childbearing potential who is not using an effective method of pregnancy prevention?	Y	N

Note to Pharmacist: *do not dispense unless 'Y'*

☐ Woman of childbearing potential

The patient has been counselled about the teratogenic risk of treatment with Thalidomide Celgene®, the need to avoid pregnancy and has been using an effective method of pregnancy prevention for at least 4 weeks?	Y	N

Note to Pharmacist: *do not dispense unless 'Y*

Date of last negative pregnancy test:	DD	MM	YYYY

Note to Pharmacist: *Do not dispense unless a negative pregnancy test has been conducted within 3 days prior of the prescription date*

Prescriber Confirmation

I have read and understood the Thalidomide Celgene® Healthcare Professional's Information Pack, and confirm that the patient has signed a Treatment Initiation Form.

Prescriber First Name:				
Prescriber Last Name:				
Signature:		Date:	DD MM	YYYY

Note to pharmacist: *the date of the prescription must match the date on this prescription authorisation form.*

Pharmacy Confirmation

I am satisfied that the Thalidomide Celgene® prescription authorisation form has been completed fully, confirm that dispensing is taking place within 7 days of the prescription date and that I have read and understood the 'Thalidomide Celgene® Healthcare Professional's Information Pack

Pharmacist First Name:				
Pharmacist Last Name:				
Signature:		Date:	DD MM	YYYY