# Imnovid®▼(pomalidomide) Pharmacy Registration Form

**To be completed by the Chief/Superintendent Pharmacist or appointed deputy pharmacist.**

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| Pharmacy Name (include all legal / trading names): | |
| Chief/Superintendent Pharmacist (or appointed deputy pharmacist): | |
| Contact telephone number: | |
| Email: | |
| PSI Registration Number: | |
| Dispensing Pharmacy Address: | Delivery Address (if different): |
| Eircode: | Eircode: |
| Tel: | Tel: |
| Fax: | Fax: |
| Email: | Email: |
| Ordering Address (if different to delivery address): | |
| Eircode: | |

On behalf of . . . . . [pharmacy name], I agree to implement the following risk minimisation procedures when dealing with prescriptions for pomalidomide as specified by BMS in the Imnovid® Healthcare Professionals' Information Pack.

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| **1** | I have read and understood the Imnovid® Healthcare Professionals' Information Pack. | TICK |
| **2** | All pharmacists who dispense Imnovid® will have read and understood the Imnovid® Healthcare Professionals' Information Pack. | TICK |
| **3** | If supplied with Imnovid®, it will only be used for the purpose of dispensing the product by the Pregnancy Prevention Programme registered pharmacy to the patient. | TICK |
| **4** | Prescriptions for Imnovid® will be dispensed only if accompanied by a completed Imnovid® Prescription Authorisation Form. | TICK |
| **5** | The pharmacist dispensing Imnovid® will check each prescription and Prescription Authorisation Form for completeness and countersign the authorisation form prior to dispensing. | TICK |
| **6** | Compliance with these procedures will be audited by the Chief/Superintendent Pharmacist or appointed deputy pharmacist at least annually. Audit results will be made available to BMS so that their obligation to report to the regulatory agencies on the overall effectiveness of the programme can be met. | TICK |
| **7** | Imnovid® will be dispensed, checked and stored according to our standard documented procedures for oral anti-cancer medicines. | TICK |
| **8** | Dispensing will be limited to no more than a 4 week supply for women of childbearing potential, and 12 weeks for males and women of non-childbearing potential. | TICK |
| **9** | Dispensing of Imnovid® to women of childbearing potential should occur within 7 days of the prescription. | TICK |
| **10** | After dispensing, Imnovid® Prescription Authorisation Forms will be kept in pharmacy for a minimum of 2 years. | TICK |
| **11** | Pharmacies must undertake the mandatory annual self-audit of the Imnovid® Prescription Authorisation Forms. | TICK |
| **12** | I will notify BMS of any change in contact details. | TICK |

I understand that registration to obtain and supply Imnovid® will only be granted if I agree to items 1–12 described above as supply of Imnovid® without participation in the required risk minimisation for pregnancy prevention is contrary to the conditions of the marketing authorisation. Registration is valid for 2 years at which point I will confirm that we are continuing to follow the risk minimisation procedures by completing this form and sending to BMS.

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|---|---|---|---|---|
| Sign: | | | | |
| Print: | Date: | DD | MM | YYYY |

**Fax the completed form to BMS on 1800 992 429 or email to rmpukire@bms.com**

▼ This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information.