Lenalidomide Prescription Authorisation Form (PAF)

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

Name of treating Hospital:	
Patient date of birth:DD/MM/YYYY	**Patient ID number/Initials:**
Prescriber (PRINT):	
Supervising Physician:	

Indication (tick)

- ☐ Multiple Myeloma
- ☐ Myelodysplastic Syndromes with isolated del5q cytogenetic abnormality
- ☐ Mantle Cell Lymphoma relapsed and/or refactory
- ☐ Follicular Lymphoma
- ☐ Other (please specify) _____

Capsule strength prescribed (tick) / Quantity of capsules prescribed(*do not enter number of packs)

☐ 2.5 mg	☐ 5 mg	☐ 7.5 mg	☐ 10 mg	☐ 15 mg	☐ 20 mg	☐ 25 mg
Quantity*	Quantity*	Quantity*	Quantity*	Quantity*	Quantity*	Quantity*

Number of cycles prescribed:

Please tick all boxes that apply

Woman of non-childbearing potential	TICK		
Male	TICK		
The patient has been counselled about the teratogenic risk of treatment with lenalidomide and understands the need to use a condom if involved in sexual activity with a woman of childbearing potential not using effective contraception or if their partner is pregnant (even if the patient has had a vasectomy).		Y	N

Note to pharmacists – do not dispense unless ticked 'Y' for male patients

Woman of childbearing potential	TICK		
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 or committed to absolute and continuous abstinence confirmed on a monthly basis.		Y	N
Date of last negative pregnancy test	DD	MM	YYYY

Note to pharmacists – do not dispense unless ticked 'Y' and a negative test has been conducted within 3 days prior of the prescription date and dispensing is taking place within 7 days of the prescription date

Both signatures must be present prior to dispensing lenalidomide.

Prescriber's declaration

As the Prescriber, I have read and understood the lenalidomide Healthcare Professional's Information Guide. I confirm the information provided on this PAF is accurate, complete and in accordance with the requirements of the Pregnancy Prevention Programme for lenalidomide. I confirm treatment has been initiated and is monitored under the supervision of a physician with expertise in managing immunomodulatory or chemotherapeutic agents.

Sign	Print
Date DD MM YYYY	Bleep number

Pharmacist's declaration

I am satisfied that this **Lenalidomide** Prescription Authorisation Form has been completed fully and that I have read and understood the **Lenalidomide** Healthcare Professional's Information Guide. For women of childbearing potential, dispensing will be taking place within 7 days of the date of prescription. I am dispensing no more than a 4 weeks supply to women of childbearing potential and 12 weeks for males and women of non-childbearing potential.

Sign	Print
Date	DD MM YYYY
Name of dispensing pharmacy	
Lenalidomide Brand dispensed	