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

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

Name of Treating Hospital:	
Patient Date of Birth: DD MM YYYY	Patient ID Number/Initials:
Prescriber: (print)	
Supervising Physician name: (print)	
Indication: (tick)	☐ **Relapsed and Refractory Multiple Myeloma**
	☐ **Multiple Myeloma**
If other please specify:	

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

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 pomalidomide 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 pharmacist – do not dispense unless ticked and, for a male, Y selected

Woman of childbearing potential	TICK	
The patient has been counselled about the teratogenic risk of treatment, 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 pharmacist – do not dispense unless ticked, Y selected for counselling 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 pomalidomide

Prescriber's declaration

As the Prescriber, I have read and understood the Healthcare Professionals' Information Pack. I confirm the information provided on this PAF is accurate, complete and in accordance with the requirements of the Pregnancy Prevention Programme for pomalidomide. 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	

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

Pharmacist's declaration

I am satisfied that this Prescription Authorisation Form has been completed fully and that I have read and understood the Healthcare Professionals' Information Pack. 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-week supply to women of childbearing potential and 12-weeks for males and women of non-childbearing potential.

Sign	Print
Date DD MM YYYY Bleep	
Name and postcode of dispensing pharmacy	

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

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