Lenalidomide Prescription Authorisation Form

Completion of this information is mandatory for ALL patients. A newly completed copy of this form must accompany EVERY lenalidomide prescription. 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 name: (print)

Indication (tick)

- Multiple myeloma ☐
- Mantle cell lymphoma relapsed and/or refractory ☐
- Myelodysplastic syndromes with isolated del5qcytogenetic abnormality ☐
- Follicular lymphoma ☐
- Other (please specify) ☐

Capsule strength prescribed: (tick) 2.5mg☐ 5mg☐ 7.5mg ☐ 10mg☐ 15mg☐ 20mg ☐ 25mg☐ ☐

Quantity of **Capsules** prescribed: *
* Do **NOT** enter number of packs

Enter the cycle number(s) prescribed for this patient

Please tick all boxes that apply

Woman of non-childbearing potential Yes☐ No☐

Male Yes☐ No☐

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). Yes☐ No☐

Note to pharmacist – Do not dispense unless ticked YES for Male patients

Woman of childbearing potential Yes☐ No☐

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. Yes☐ No☐

Date of last negative pregnancy test:

Note to pharmacist – Do not dispense unless ticked yes and a negative test has been conducted within 3 days prior to 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 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	Bleep

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, the 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	Bleep

Name and postcode of dispensing pharmacy

Lenalidomide brand dispensed: