Thalidomide Prescription Authorisation Form

A newly completed copy of this form MUST accompany EVERY THALIDOMIDE prescription. Completion of this information is mandatory for ALL patients.

Name of treating Hospital

Patient Date of Birth D D M M Y Y Y Y Patient ID Number/Initials

Prescriber: (print)

Supervising physician: (print)

Indication: (tick) Multiple Myeloma ☐ Other ☐

If other please specify:

If this patient is being treated privately, tick here ☐

Dose prescribed	
Quantity of **Capsules per cycle** prescribed*	
Number of cycle(s) prescribed	1 ☐ 2 ☐ 3 ☐
Total number of Capsules	

* Do **NOT** enter number of Packs

Woman of non-childbearing potential (maximum 12-week supply) TICK

Male (maximum 12-week supply) TICK

The patient has been counselled about the teratogenic risk of treatment with thalidomide 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 (maximum 4 weeks prescription only) 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 D D M M Y Y Y Y

Note to pharmacist – Do not dispense thalidomide unless negative pregnancy test was conducted within 3 days of the prescription date and dispensing is taking place within 7 days of the prescription date.

Both signatures must be present prior to dispensing thalidomide

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 PPP for thalidomide. I confirm treatment has been initiated and is monitored under the supervision of a physician experienced in managing immunomodulatory drugs.

Sign Date D D M M Y Y Y Y

Bleep

Print

Note to pharmacist – Every prescription must be accompanied by an accurately completed PAF

Pharmacist's declaration

I am satisfied that this Thalidomide PAF has been completed fully and that I have read and understood the Thalidomide Healthcare Professionals'Information Pack.

For a woman of childbearing potential, dispensing will be taking place within 7 days of the date of prescription. I am dispensing no more than 4 weeks supply to women of childbearing potential and 12 weeks for males and women of non-childbearing potential.

Sign Date D D M M Y Y Y Y

Bleep

Print

Name and postcode of dispensing pharmacy

Home delivery information

Name and postcode of home delivery company used, if applicable.

A copy of every completed PAF should be sent to Bristol-Myers Squibb (BMS) immediately after dispensing via email to: paf.uk.ire@bms.com, or fax to: 0808 100 9910

Date faxed to BMS D D M M Y Y Y Y Faxed by (Name)

Date of preparation of text: January 2022

Date approved by MHRA: March 2022

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