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

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

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)

Diagnosis: (tick)
- ☐ **Relapsed and Refractory Multiple Myeloma**
- ☐ **Multiple Myeloma**
- Other ☐ If other please specify usage:

If this patient is being treated privately, tick here ☐

Capsule strength prescribed: (tick)	1mg ☐	2mg ☐	3mg ☐	4mg ☐
Quantity of **Capsules** per cycle prescribed:*				

Number of cycle(s) prescribed 1 ☐ 2 ☐ 3 ☐

Total number of capsules:

* Do **NOT** enter number of Packs

Please tick all boxes that apply

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

	Y	N
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).		

Note to pharmacist – Do not dispense unless ticked and, for a male, Y selected

	TICK
Woman of childbearing potential (maximum 4 weeks prescription only)	

	Y	N
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.		

Date of last negative pregnancy test D D M M Y Y Y Y

Note to pharmacist – Do not dispense pomalidomide 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 IMNOVID

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 pomalidomide. 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 IMNOVID PAF has been completed fully and that I have read and understood the IMNOVID 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 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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