RISK AWARENESS FORM FOR COUNSELLING THE PATIENT TO ENSURE THE PATIENT IS FULLY INFORMED ABOUT THE SAFE USE OF POMALIDOMIDE.

This Risk Awareness Form is to assist you with counselling a patient before they commence pomalidomide treatment in order to ensure it is used safely and correctly. It must be completed for each woman of non-childbearing potential prior to the initiation of their pomalidomide treatment.

The purpose of the Risk Awareness Form is to protect patients and any possible foetuses by ensuring that patients are fully informed of and understand the risk of teratogenicity and other adverse drug reactions associated with the use of pomalidomide. It is mandatory that woman of non-childbearing potential receive counselling and education to be made aware of the risks of pomalidomide.

The form should be retained with their medical records, and a photocopy provided to the patient. It is not a contract and does not absolve anybody from his/her responsibilities regarding the safe use of the product and prevention of foetal exposure.

Warning: Pomalidomide must not be taken during pregnancy, since a teratogenic effect in humans is expected. Pomalidomide is structurally related to thalidomide. Thalidomide is a known human teratogen that causes severe life-threatening birth defects. Pomalidomide was found to be teratogenic in both rats and rabbits when administered during the period of major organogenesis. The conditions of the Pregnancy Prevention Programme must be fulfilled for all patients unless there is reliable evidence that the patient does not have childbearing potential.

If pomalidomide is taken during pregnancy it is expected to cause severe birth defects or death to an unborn baby.

Patient Details

Patient First Name	
Patient Last Name	

Date of Birth	DD	MM	YYYY	Counselling Date	DD	MM	YYYY

Did you inform your patient:

	Woman of Non-Childbearing Potential
1. To not share the medicinal product with any other person.	Tick
2. That they should not donate blood during treatment (including during dose interruptions) and for at least 7 days following discontinuation of pomalidomide.	Tick
3. That they should return the unused capsules to the pharmacist at the end of treatment	Tick
4. Of hazards and necessary precautions associated with use of pomalidomide.	Tick
5. Of the thromboembolic risk and possible requirement to take thromboprophylaxis during treatment with pomalidomide.	Tick

Prescriber Confirmation

I have fully explained to the patient named above the nature, purpose and risks of the treatment associated with pomalidomide especially the risks to women of childbearing potential. I will comply with all my obligations and responsibilities as the prescriber of pomalidomide.

Prescriber First Name	
Prescriber Last Name	

Prescriber Signature		Date	DD	MM	YYYY

Patient: please read thoroughly and initial the adjacent box if you agree with the statement

I understand that severe birth defects may occur with the use of pomalidomide. I have been warned by my prescriber that any unborn baby has a high risk of birth defects and could even die if a woman is pregnant or becomes pregnant while taking pomalidomide.	Patient Initials
I understand that pomalidomide will be prescribed ONLY for me. I must not share it with ANYONE.	Patient Initials
I have read the Pomalidomide Patient Guide and understand the contents, including the information about other possible important health problems (side effects) associated with the use of pomalidomide.	Patient Initials
I know that I cannot donate blood while taking pomalidomide (including dose interruptions) and for at least 7 days after stopping treatment.	Patient Initials
I understand that I must return any unused pomalidomide capsules to my pharmacy at the end of my treatment	Patient Initials
I have been informed about the thromboembolic risk and possible requirement to take thromboprophylaxis during treatment with pomalidomide	Patient Initials
I understand that my prescriber will send or may provide me with a completed 'Prescription Authorisation Form' with each pomalidomide prescription for the pharmacy	Patient Initials
I understand that the 'Prescription Authorisation Form' contains non-identifiable information about me, which will ensure pomalidomide is dispensed safely. This information may be used by the Marketing Authorisation Holder and the distributor for the product I receive and the Health Products Regulatory Authority (HPRA) to evaluate the safe use of pomalidomide.	Patient Initials

Patient Confirmation

I confirm that I understand and will comply with the requirements of the POMALIDOMIDE Pregnancy Prevention Programme, and I agree that my prescriber can initiate my treatment with pomalidomide.

Your personal data is used solely for the purpose of entering you into the Pomalidomide Pregnancy Prevention Programme and is processed by the marketing authorisation holder (MAH) of the pomalidomide product you receive, its third party service providers and any worldwide Affiliates the MAH may have, for the purposes of compliance with the Risk Management Plan legal obligations and for storage purposes. Third party service providers include, for example, the distributor of the pomalidomide product you receive.

Your pharmacist can confirm the details of the MAH for the pomalidomide product you are given and this will also be mentioned on the packaging and package leaflet. Queries on how your personal data will be processed can be directed to the MAH in question, by consulting their publicly available information (e.g. on their website) which details how they process your personal data and provides a contact point for any queries in relation to their use of your personal data.

Patient Signature		Date	DD	MM	YYYY

Statement of the interpreter (where appropriate)

I have interpreted the information above to the patient/parent/carer to the best of my ability and in a way in which I believe she/he/they can understand. She/he/they agree to follow the necessary precautions to prevent an unborn child being exposed to pomalidomide.

Signed		Name: (Print)		Date	DD	MM	YYYY

Important Safety Information:

This is risk minimisation material and is provided as a collaborative project between Accord Healthcare Ireland Ltd. AS Grindeks and Teva Pharmaceuticals Ireland. For further information, please refer to the Summary of Product Characteristics (SmPC) for the respective medicinal product from the relevant Marketing Authorisation Holder available at www.hpra.ie

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