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 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						
☐ Relapsed and Refractory Multiple Myeloma						
☐ If other please specify:						
Capsule strength prescribed: (tick)	☐ 1 mg	☐ 2 mg	☐ 3 mg	☐ 4 mg		
Quantity of **capsules per cycle** prescribed* (*Do not enter number of packs)	Quantity*	Quantity*	Quantity*	Quantity*		
Number of cycle(s) prescribed:						

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 pharmacists - **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 pharmacists - **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 Pomalidomide 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 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 number

Note to pharmacist - **Prescription must be accompanied by a Prescription Authorisation Form**

Pharmacist's declaration

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

Sign	Print
Date	DD MM YYYY
Name and postcode of dispensing pharmacy	
Pomalidomide brand you have dispensed	