Biologix

Bristol Myers Squibb™

i-SECURE

HCP Registration Form
Imnovid®(Pomalidomide)

This educational material is part of the marketing authorization and has been approved by the SFDA in August 2023

Healthcare Professionals Registration Form

As a part of the Pregnancy Prevention Program (PPP) for immunomodulatory agent (pomalidomide), this document must be returned to Biologix representative to confirm receipt of the information kit.

The i-SECURE information kit includes the HCP Brochure, Patient Agreement Form and HCP Checklist, Product Handling Instructions for Immunomodulatory Agents, Patient Brochure and the Verification Form.

Please complete this form in BLOCK CAPITAL LETTERS.

HEALTHCARE PROFESSIONAL INFORMATION		
Please check the appropriate box	☐ **Prescriber**	☐ **Pharmacist**
First Name		
Last Name		
Specialty		
Institution Name		
Address		
Country		
Phone Number		
Fax Number		
Email Adress		

Data Privacy Notice

Your personal data will be processed by Biologix for the purposes of administering on behalf of Bristol-Myers Squibb (BMS) the PPP.

We may share your data with BMS entities and third parties providing services to BMS for PPP management and administration purposes. This may entail the transfer of your data to other countries such as the USA and Switzerland. BMS will implement appropriate contractual, organizational, and technical security measures to protect your information from unauthorized access, use or disclosure. If required, we may share your data with health authorities for safety and other regulatory reasons.

For more information on how your personal data is being processed, contact Biologix at BX-Privacy-KSA@biologixpharma.com

Prescriber Confirmation

I hereby acknowledge that I have received training on i-SECURE, read and understood the information detailed in the healthcare professional educational materials (i-SECURE HCP Brochure), particularly the risk of fetal exposure, and the steps needed to mitigate the teratogenic risk of immunomodulatory agents. I shall comply with the PPP requirements, explain associated risks to patients with immunomodulatory agents, and I confirm understanding of my responsibility to ensure that patients meet all the conditions of PPP before the product is prescribed and dispensed.

By signing this form, I consent to the processing of my personal data.

Signature _____ **Date** _____

Please provide this form to Biologix Medical Department:
Email: medinfo@biologixpharma.com