



# Pomalidomide SPC<sup>®</sup> (Pomalidomide)

## Pharmacy Registration Form

To be completed by the Chief Pharmacist or appointed deputy.

Hospital Name:

Chief Pharmacist (or appointed deputy):

Contact telephone number:

Email:

On behalf of ..... [institution name], I agree to implement the following risk minimization procedures when dealing with prescriptions for **Pomalidomide SPC<sup>®</sup>** as specified by Sudair Pharma in the **Pomalidomide SPC<sup>®</sup>** Healthcare Professional's Information Pack.

1 **Pomalidomide SPC<sup>®</sup>** will be dispensed, checked and stored according to our standard documented procedures for oral anti-cancer medicines.

2 Prescriptions for **Pomalidomide SPC<sup>®</sup>** will be dispensed only if accompanied by a completed **Pomalidomide SPC<sup>®</sup>** Prescription Authorization Form.

3 All pharmacists who dispense **Pomalidomide SPC<sup>®</sup>** will have read and understood the **Pomalidomide SPC<sup>®</sup>** Healthcare Professional's Information Pack.

4 The pharmacist dispensing **Pomalidomide SPC<sup>®</sup>** will check each prescription and Prescription authorization Form for completeness and countersign the authorization form prior to dispensing.

5 Dispensing will be limited to no more than a 4-week supply for women of childbearing potential, and 12 weeks for males and women of non-childbearing potential. dispensing should occur within a maximum of 7 days of the date of prescription.

6 After dispensing, **Pomalidomide SPC<sup>®</sup>** Prescription Authorization Forms will be kept in pharmacy for a minimum of 2 years. A copy of each completed Prescription Authorization Form will be sent to Sudair Pharma.

7 The information supplied to Sudair Pharma on Prescription Authorization Forms will be used to provide anonymized aggregate reports to the regulatory agencies to assess the implementation of the Pregnancy Prevention Programme.

8 I have read and understood the **Pomalidomide SPC<sup>®</sup>** Healthcare Professional's Information Pack.

I understand that registration to obtain and supply **Pomalidomide SPC<sup>®</sup>** will only be granted if I agree to items 1-8 described above. Registration is valid for 2 years at which point I will confirm that we are continuing to follow the risk minimization procedures by completing this form and sending to Sudair Pharma Pharmacovigilance Department.

Signature

Print:

Date:

DD / MM / YYYY