Pomalidomide SPC® (Pomalidomide)

Prescription Authorisation Form (PAF)

*This document has been reviewed and approved by The **Saudi Food and Drug Authority (SFDA).***
Version: 1.0** | **Date: December 2022

SPC سـديـر للأدويـة

Patient Information:

Hospital Name: .....

Patient date of birth: ..... / / .....

MRN No: .....

Diagnosis: .....

Doctor (name): .....

Daily Dose: .....

Frequency: ..... Duration: .....

Patient Risk Category - Please tick all boxes that apply

Women of non-childbearing potential ☐

Male

The patient has been counseled about the teratogenic risk of treatment with **Pomalidomide SPC®** and understands the need to use a condom if involved in sexual activity with a woman of childbearing potential (even if the patient has had a vasectomy). ☐

Women of childbearing potential

The patient has been counseled about the teratogenic risk of treatment and the need to avoid pregnancy, and has been on effective contraception for at least 4 weeks? ☐

Date of last negative pregnancy test Hospital ..... / / .....

Note to pharmacist – do not dispense unless ticked and a negative test has been conducted within 3 days prior of the prescription date

Date sent to SPC ..... / / ..... Sent by (Name) .....

Both signatures must be present prior to dispensing Pomalidomide SPC®

Prescriber's declaration (Consultants only)

I am a physician experienced in managing haematological malignancy and I have read and understood the **Pomalidomide SPC®** Healthcare Professional's Information Pack and confirm that the patient has signed an informed consent for **Pomalidomide SPC®** treatment.

Sign /stump	Date / /
	Time

Note to pharmacist – prescription and Prescription Authorisation Form must have the same date

Pharmacist's declaration

I am satisfied that this Pomalidomide SPC® Prescription Authorisation Form has been completed fully, confirm that dispensing is taking place within 7 days of the date of prescription and that I have read and understood the Pomalidomide SPC® Healthcare Professional's Information Pack.

Strength	1 mg	2 mg	3 mg	4 mg
Quantity				

Pharmacist Name	Hospital
Signature	Date / /