REVLIMID® ▼
(lenalidomide)

Pregnancy Prevention Programme (PPP)

Woman of Non-Childbearing Potential Treatment Initiation Form

UK
Version 10

▼ This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information.

Healthcare professionals are asked to report any suspected adverse reactions using the Yellow Card Scheme via www.mhra.gov.uk/yellowcard or by searching for MHRA Yellow Card in the Google Play or Apple App Store. Adverse reactions should also be reported to Bristol-Myers Squibb (BMS) Medical Information on 0800 731 1736 or medical.information@bms.com.

Date of preparation of text: April 2022
Approved by MHRA: November 2022

2003-GB-2200040

Introduction

This Treatment Initiation Form must be completed for each woman of non-childbearing potential prior to the initiation of their Revlimid treatment. The form should be retained with their medical records, and a copy provided to the patient.

It is mandatory that women of non-childbearing potential receive counselling and education to be made aware of the risks of Revlimid.

The aim of the Treatment Initiation 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 effects associated with the use of Revlimid.
It is not a contract and does not absolve anybody from his/her responsibilities with regard to the safe use of the product and prevention of foetal exposure.

Warning: Lenalidomide is structurally related to thalidomide. Thalidomide is a known human teratogenic active substance that causes severe life-threatening birth defects. Lenalidomide induced in monkeys malformations similar to those described with thalidomide. If lenalidomide is taken during pregnancy, a teratogenic effect of lenalidomide in humans is expected. 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 lenalidomide 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*

Prescriber Confirmation

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

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 are expected to occur with the use of Revlimid. 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 Revlimid.	*Patient initials*
I have read the Revlimid Patient Brochure and understand the contents, including the information about other possible important health problems (side effects) associated with the use of Revlimid.	*Patient initials*
I understand that Revlimid will be prescribed ONLY for me. I must not share it with ANYONE.	*Patient initials*
I know that I cannot donate blood while taking Revlimid (including dose interruptions) and for at least 7 days after stopping treatment.	*Patient initials*
I understand that I must return any unused Revlimid 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 Revlimid.	*Patient initials*

Patient Confirmation

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

This form will be kept by your doctor. Your personal data (collected on the prescription authorisation form or "PAF") will be processed by Bristol-Myers Squibb Pharma EEIG ("BMS"), as the marketing authorisation holder of Revlimid for the purpose(s) of managing the Pregnancy Prevention Programme.

Your data will be kept for as long as necessary, for the purposes of compliance with the Risk Management Plan legal obligations and for storage purposes.

Should you have any queries in relation to the use of your personal data please contact your doctor or BMS at: eudpo@bms.com. If you are unhappy about how your personal data is being processed, you have the right to lodge a complaint with the supervisory authority.

Patient Signature:		Date:	*DD*	*MM*	*YYYY*

Statement of the interpreter (where appropriate)

I have interpreted the information above to the patient/parent 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 Revlimid.

Interpreter Signature:		Name: (print)		Date:	*DD*	*MM*	*YYYY*

Bristol Myers Squibb™

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