Revlimid® Treatment Initiation Form

Men

This Treatment Initiation Form must be completed for each male patient prior to the initiation of their Revlimid® treatment. **The form should be retained with their medical records, and a copy provided to the patient.**

The aim of the Treatment Initiation Form is to assist both prescribers and patients to ensure all necessary steps are taken to prevent foetal exposure to lenalidomide and to assist in ensuring that patients are fully informed of and understand the risk of teratogenicity and other adverse effects associated with the use of lenalidomide. 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.

Patient Name **Date of Birth**

	Insert √
Inform of expected teratogenic risk to the unborn child	
Inform of need to use condoms (even if he has had vasectomy) throughout treatment duration, during dose interruption, and for 7 days after cessation of treatment if partner is pregnant or of childbearing potential who is not using effective contraception.	
Inform patient not to share medication	
Inform to return unused capsules to pharmacist	
Inform not to donate blood whilst taking Revlimid® or for 7 days after stopping	
Inform of hazards and necessary precautions associated with use of Revlimid®	
Inform about the thromboembolic risk and possible requirement to take thromboprophylaxis during treatment with Revlimid®	
Inform about which are effective contraceptive methods that the female partner of a male patient can use	
Inform that if his female partner becomes pregnant whilst he is taking Revlimid® or shortly after he has stopped taking Revlimid®, he should inform his treating physician immediately and that it is recommended to refer the female partner to a physician specialised or experienced in teratology for evaluation and advice.	

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 prescribing physician of Revlimid®

Physician Name

Physician Signature **Date**

Patient Name **Date of Birth**

Patient: please read thoroughly and initial the adjacent box if you agree with the statement

My doctor has explained to me and I have understood the possible risks and the possible benefits associated with Revlimid® (lenalidomide). I have had the opportunity to ask questions and I have understood the answers provided to those questions.	*Patient initials*
I have received, read and understood the Patient Information Brochure	*Patient initials*
I understand that Revlimid® (lenalidomide) has been prescribed for me personally and that I should not share it with any other person even if they have the same condition as me. I should store Revlimid® (lenalidomide) out of the reach of children.	*Patient initials*
I will return any unused capsules to my pharmacist.	*Patient initials*
I will not donate blood during treatment or for 7 days after stopping treatment	*Patient initials*
I understand that Revlimid® (lenalidomide) is expected to be harmful to the unborn child	*Patient initials*
I agree to use condoms (even if I have had vasectomy) throughout treatment duration, during dose interruption, and for one week after cessation of treatment if my partner is pregnant or of childbearing potential not using effective contraception.	*Patient initials*
If my partner were to become pregnant during my treatment with Revlimid® (lenalidomide), I will advise her to seek medical advice immediately.	*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 doctor can initiate my treatment with Revlimid®

Patient Signature **Date**

