Imnovid® (pomalidomide) Patient Card

Patient Card for Imnovid® (pomalidomide)

Patient Initials: Date of Birth:

Physician Name:
Physician Address:
Physician Phone number:

Physician to complete each section.

1. Indication (please specify in detail i.e. relapsed/refractory multiple myeloma (rrMM) with at least 2 prior treatment regimens (including both lenalidomide and bortezomib):

2. Status of Patient (tick one)

- Male ☐
- Woman of non-childbearing potential* ☐

(*no Pregnancy Prevention Programme (PPP) monitoring required.)

- Woman of childbearing potential ** ☐

**Please also complete section 4.

3. Counselling regarding the expected human teratogenicity of Imnovid® and the need to avoid pregnancy has been provided before first prescription.

Physician's signature
Date

Copy of Patient Card to be given to patient.

4. For Woman of Childbearing potential

Date of visit	Patient is using one effective method of contraception (Yes/No)	Date of NEGATIVE pregnancy test (IF APPLICABLE)	Confirmed no risk of pregnancy (PLEASE TICK)	Date of Imnovid® prescription	Physician signature	Dispensed by	Dispensed date

*Women of childbearing potential must have a medically supervised negative pregnancy test prior to issuing a prescription (with a minimum sensitivity of 25 mIU/ml) once she has been established on contraception for 4 weeks, at 4 weekly intervals during therapy (this includes dose interruptions) and 4 weeks after the end of therapy (unless confirmed tubal sterilisation). This includes those women of childbearing potential who confirm absolute and continued abstinence. For further information, refer to the Summary of Product Characteristics.

