# Pharmacy Registration Form

You will need to complete the relevant registration form in order to obtain lenalidomide.

# Lenalidomide

## Lenalidomide Rowex (lenalidomide) Pharmacy Registration Form – Part I
## To be completed by the Chief/Superintendent Pharmacist or appointed deputy

| | |
|---|---|
| Institution name: | |
| Chief/'Superintendent Pharmacist (or appointed deputy): | |
| Contact telephone number: | |
| Email: | |
| Dispensing Pharmacy Address: | Delivery Address (if different): |
| Tel: | Tel: |
| Fax: | Fax: |
| Email: | Email: |
| Ordering Address (if different to delivery address): | |

On behalf of .....[institution name], I agree to implement the following risk minimization procedures when dealing with prescriptions for lenalidomide as specified by Rowex Ltd, in the Lenalidomide Rowex Healthcare Professional's Information Pack.

| | | |
|---|---|---|
| ***1.*** | I have read and understood the lenalidomide Rowex Healthcare Professional's Information Pack | ☐ |
| ***2.*** | All pharmacists who dispense lenalidomide Rowex will have read and understood the lenalidomide Healthcare Professional's information pack | ☐ |
| ***3.*** | If supplied with lenalidomide Rowex, it will only be used for the purpose of dispensing the product by the Pregnancy Prevention Programme registered pharmacy to the patient | ☐ |
| ***4.*** | Lenalidomide Rowex will be dispensed, checked and stored according to our standard documented procedures for oral anti-cancer medicines. | ☐ |
| ***5.*** | Prescriptions for Lenalidomide Rowex will be dispensed only if accompanied by a completed lenalidomide Prescription Authorization Form. | ☐ |
| ***6.*** | The pharmacist dispensing Lenalidomide Rowex will check each prescription and Prescription Authorization Form for completeness and countersign the authorization form prior to dispensing. | ☐ |
| ***7.*** | 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 child bearing potential. | ☐ |
| ***8.*** | Dispensing of lenalidomide Rowex to women of childbearing potential should occur within 7 days of the prescription | ☐ |
| ***9.*** | After dispensing, lenalidomide Prescription Authorization Forms will be kept in pharmacy for a minimum of 2 years. | ☐ |
| ***10.*** | Pharmacies must undertake the mandatory annual self-audit of the PAFs | ☐ |
| ***11.*** | Compliance with these procedures will be audited by the chief/superintendent pharmacist or appointed deputy at least annually. Audit results will be made available to Rowex so that their obligation to report to the regulatory agencies on the overall effectiveness of the programme can be met. | ☐ |
| ***12*** | I will notify Rowex of any change in contact details. | ☐ |

I understand that registration to obtain and supply Lenalidomide Rowex will only be granted if I agree to items 1–12 described above as supply of Lenalidomide Rowex without participation in the required risk minimisation for pregnancy prevention is contrary to the conditions of the marketing authorisation.

Registration is valid for 2 years at which point I will confirm that we are continuing t minimization procedures by completing this form and sending to the Rowex.

Sign:

Print:

Date: DD MM YYYY

Fax the completed forms to Rowex on 027 50417 or email to pv@rowa-pharma.ie

## Lenalidomide Rowex (lenalidomide) Pharmacy Registration Form – Part II

### If you would like to register additional pharmacy sites to be covered by your registration please provide details below.

**Institution name:**

Additional pharmacy sites covered by registration with Rowex to supply Lenalidomide Rowex.

| Name of Hospital/Pharmacy: | |
|---|---|
| Delivery Address: | Invoice Address (if different): |
| Tel: | Tel: |
| Fax: | Fax: |
| Email: | Email: |

| Name of Hospital/Pharmacy: | |
|---|---|
| Delivery Address: | Invoice Address (if different): |
| Tel: | Tel: |
| Fax: | Fax: |
| Email: | Email: |

| Name of Hospital/Pharmacy: | |
|---|---|
| Delivery Address: | Invoice Address (if different): |
| Tel: | Tel: |
| Fax: | Fax: |
| Email: | Email: |

Fax the completed forms to Rowex on 027 50417 or email to pv@rowa-pharma.ie