Cipla

LENALIDOMIDE CIPLA PRESCRIPTION AUTHORISATION FORM

A newly completed *Prescription Authorisation Form* must accompany every **LENALIDOMIDE CIPLA** prescription. Completion of this form is mandatory for ALL patients.

TO BE COMPLETED BY PRESCRIBER ***Please complete in block letters.***

Patient Details

Patient Name:								
Patient's Date of Birth: DD/MM/YYYY								
Indication (tick)	Multiple Myeloma		Other (please specify)					
	Line of therapy		1st		2nd		3rd	4th
Dose of **LENALIDOMIDE CIPLA** prescribed:								
Number of cycles prescribed:		1		2		3		
Adverse events experienced during previous cycle(s):								
Serious adverse events experienced during previous cycle(s):								
If female of childbearing potential: **Date of Pregnancy Test:** DD/MM/YYYY			Results of Pregnancy Test:					

Declaration by the Prescriber
I am a physician experienced in the use of anti-cancer drugs, and I have read and understood the ***Cipla Risk Management Support Programme*** Healthcare Professional Information Brochure. I confirm that the patient has been counselled on the potential risks associated with **LENALIDOMIDE CIPLA** and has signed a **LENALIDOMIDE CIPLA** *Treatment Initiation Form*, I have reported all adverse events experienced by the patient to Cipla Medipro (Pty) Ltd.

Prescriber Name and Surname:	**Date:** DD/MM/YYYY
	Prescriber Signature:

TO BE COMPLETED BY PHARMACIST

Declaration by the Pharmacist
I have read and understood the ***Cipla Risk Management Support Programme*** Healthcare Professional Information Brochure. I confirm that the **LENALIDOMIDE CIPLA** *Prescription Authorisation Form* has been completed and I am dispensing no more than a 4-week supply to females of childbearing potential and a 12-week supply to males and females not of childbearing potential.
Note to pharmacist: *the date of the prescription and the Prescription Authorisation Form must match. Do not dispense unless the pregnancy test is negative and was done within the last 7 days.*

Dose of LENALIDOMIDE CIPLA dispensed:	_____ **mg** _____ **days**
Pharmacy Name:	**Date:** DD/MM/YYYY
	Pharmacist Name:
	Pharmacist Signature:

Signatures of Prescriber & Pharmacist must be present before dispensing LENALIDOMIDE CIPLA.

Home Delivery Company:
Name (if relevant)**:**

S4 Reg. No. 55/32/0295.294, 53/32/0374.371, 0375.372, 0376.373. Lenalidomide Cipla 5 / 10 / 15 / 25 mg. Each hard gelatin capsule contains 5 mg; 10 mg; 15 mg; 25 mg of lenalidomide.
For full prescribing information, refer to the Professional Information approved by the medicines regulatory authority.
CIPLA MEDPRO (PTY) LTD. Co. Reg. No. 1995/004182/07. Building 9, Parc du Cap, Mispel Street, Bellville, 7530, RSA. Website: www.cipla.co.za Customer Care: 080 222 6662. [587832454a]