Patient Card (8a)

Dear Physician,

Please sign each page.

Name of medicine: ☐ **Revlimid®**

☐ **Thalidomide Celgene®**

☐ **Imnovid®**

Patient details

Patient Initials: _____

I.D. Number: _____

Year of birth: _____

Sick Fund membership: _____

Diagnosis: _____

****

Prescriber details:

Prescriber name: _____

Name of the Medical Institute: _____

Address: _____

Prescriber Contact telephone number: _____

Physician to complete each section		
1. Status of Patient (tick one)		
• Woman of child-bearing potential	☐	Date of last negative pregnancy test result:_____
• Woman of non child-bearing potential	☐	
• Girl of non child-bearing potential	☐	
• Male	☐	
2. Prior to first prescription, counseling has been provided regarding the expected human teratogenicity as results of using the medicine and the need to avoid pregnancy	☐	

Signature of prescriber	**License number**

Please send the signed patient card to Neopharm (Fax No: 03-9264237)

Patient Card (8b) (continuation)
Patient's consent to treatment

☐ **Multiple Myeloma**

☐ **Myelodysplastic Syndrome (MDS)**

☐ **Other:** _____

Statement of the attending physician

I have explained the procedure to the patient.

I have explained and discussed with the patient the special precautions required to prevent the exposure of an unborn child to the medicine

- I have also discussed:
  - the therapy is likely to include
  - the advantages and disadvantages of any available alternative treatments (including lack of treatment)
  - any particular concerns of the patient

The following Brochure has been provided:

☐ Revlimid®/Thalidomide Celgene®/Imnovid® Patient Information Brochure.

Signature of prescriber	License number

Statement of patient

I hereby confirm that I have received all information from the physician and the patient information brochure.
I hereby agree to follow the necessary precautions in order to prevent an unborn child being exposed to the medicine which has been prescribed to me, in compliance with the ministry of Health regulations.
I hereby agree to include my personal details indicated in this form in the data base managed by Neopharm in accordance with the privacy protection law.

Signature: _____ Date: _____.

Name/Initials (PRINT): _____

Please send the signed patient card to Neopharm (Fax No: 03-9264237)

Patient Card (8b) (continuation)
Parent's/guardian's statement for patients

I hereby confirm that I have received all information from the physician and the patient information brochure.

☐ For patients under 18 - I hereby confirm that the minor under my care is not pregnant and not of child-bearing potential since she has not menstruated yet.

I hereby agree to follow the necessary precautions in order to prevent an unborn child being exposed to the medicine which has been prescribed to the minor under my care, in compliance with the ministry of Health regulations.

I hereby agree to include my personal details indicated in this form in the data base managed by Neopharm in accordance with the privacy protection law.

Signature: _____ Date: _____

Name/Initials (PRINT): _____