NEOPHARM

Revlimid® (lenalidomide) & Thalidomide Celgene® (thalidomide) & Imnovid® (Pomalidomide) Pharmacy Registration Form (2)

To be completed by the responsible pharmacist.

Pharmacy / Institution name: _____

Address: _____

Responsible pharmacist name: _____

Pharmacist License number: _____

Contact telephone number: _____

Email address: _____

Fax number: _____

Pharmacy statement:

On behalf of _____ [pharmacy name], I agree to implement the following risk minimization procedures when dealing with prescriptions for Revlimid®, Thalidomide Celgene® or Imnovid® as specified by Neopharm in the Revlimid® /Thalidomide Celgene® /Imnovid® healthcare professional information kit with accordance to the license of each product. For the avoidance of doubt, the pregnancy test and the result is under the physician responsibility and reporting to Neopharm.

	I hereby confirm that:
1	Revlimid®/Thalidomide Celgene®/Imnovid® will be dispensed, checked and stored according to the Israeli MOH approved PI
2	An approval should be received from Neopharm for each prescription of Revlimid®/Thalidomide Celgene®/Imnovid®
3	All pharmacists who dispense Revlimid/Thalidomide Celgene® /Imnovid® have read and understood the Revlimid®/Thalidomide Celgene®/Imnovid® healthcare professional information kit
4	Maximum day-supply for each prescription does not exceed 28 days
5	Compliance with these procedures will be subject to audits by Neopharm so that the obligation to report to the regulatory agencies on the overall effectiveness of the program can be met
6	I have read and understood the information provided in the Revlimid®/Thalidomide Celgene®/Imnovid® healthcare professional information kit

I understand that registration to obtain and supply Revlimid®/ Thalidomide Celgene® / Imnovid® will only be granted if I agree to implement all of the steps described. Registration is valid for 2 years after which I will confirm that we will continue to follow the risk minimization procedures (PPP).

Signature: _____ **Date:** _____

Please send the signed form to Neopharm (Fax No: 03-9264237). Upon receipt of this form, we will send you a confirmation of registration in the RMP/PPP.