Revlimid® (lenalidomide)
Patient Card

Patient Card for Revlimid® (lenalidomide)

Patient Initials: Date of Birth:

Physician Name:
Physician Address:
Physician Phone number:

Physician to complete each section.

1. **Indication:**

Multiple Myeloma:

☐ ndMM

☐ After at least one prior therapy: Line of therapy……

☐ Monotherapy for maintenance after autologous stem cell transplantation

Myelodysplastic Syndromes with isolated del5q cytogenetic abnormality:

☐ Low- or ☐ intermediate-1 risk

Mantle cell lymphoma relapsed and/or refractory: ☐

Other: ☐ Specify……..

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 Revlimid® and the need to avoid pregnancy has been provided before first prescription.**

Physician's signature

Copy of Patient Card to be given to patient.

Date

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 Revlimid® 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.

