IMNOVID® (POMALIDOMIDE)

PREGNANCY PREVENTION PROGRAMME

PRESCRIBER/PHARMACIST ACKNOWLEDGEMENT RECEIPT
(EXAMPLE OF EQUIVALENT TOOL)

Medicines Authority -Approval Date: *18 October 2023*

IMNOVID® (POMALIDOMIDE)
PRESCRIBER/PHARMACIST ACKNOWLEDGEMENT RECEIPT

As a part of the Pregnancy Prevention Program this document must be returned to BMS upon receipt of the information kit.

Please fill out in capital letters.

Prescriber/Pharmacist Information:

Name: _____

Specialty: _____

Organization: _____

Address:

_____

Country: _____

Phone: _____ **Fax:** _____

Email: _____

REPORTING OF ADVERSE REACTIONS

The safe use of pomalidomide is of paramount importance. As part of BMS's ongoing safety monitoring, the company wishes to learn of Adverse Reactions that have occurred during the use of pomalidomide. Please contact AM Mangion Ltd immediately on Tel No 00356 23976333 and email pv@ammangion.

Suspected Adverse Drug Reactions (side effects) or medication errors may be reported using the Medicines Authority ADR reporting form, which is available online at http://www.medicinesauthority.gov.mt/adrportal, and sent by post or email to;
P: Pharmacovigilance Section at Post-Licensing Directorate, Medicines Authority, Sir Temi Żammit Buildings, Malta Life Sciences Park, San Ġwann SĠN 3000
E: postlicensing.medicinesauthority@gov.mt

I have read and understood the information detailed in the Healthcare Professionals Brochure explaining the risks in patients receiving Imnovid® (pomalidomide), particularly the risk of foetal exposure and I will conform to the Pregnancy Prevention Program requirements.

Signature of Prescriber/Pharmacist: _____ Date: _____

Print name: _____

Signature of BMS/Partner Representative: _____ Date: _____

Print name: _____

Please provide a copy of this form to BMS at email raquilina@ammangion.com. The original must be kept by the prescriber/pharmacist.

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