

Lenalidomide Pregnancy Prevention Programme (PPP)

Male Treatment Initiation Form

UK

Prescriber Confirmation

I have fully explained to the patient named above the nature, purpose and risks of the treatment associated with lenalidomide, especially the risks to women of childbearing potential.

I will comply with all my obligations and responsibilities as the prescriber of lenalidomide.

Prescriber First Name:																				
Prescriber Last Name:																				
Prescriber Signature:													Date:	DD	MM	YYYY				

Patient: please read thoroughly and initial the adjacent box if you agree with the statement

I understand that severe birth defects are expected to occur with the use of lenalidomide. I have been warned by my prescriber that any unborn baby has a high risk of birth defects and could even die if a woman is pregnant or becomes pregnant while taking lenalidomide.	Patient initials
I understand that lenalidomide passes into human semen. If my partner is pregnant or able to become pregnant, and she doesn't use effective contraception, I must use condoms throughout the duration of my treatment, during dose interruptions and for at least 7 days after I stop lenalidomide even if I have had a vasectomy.	Patient initials
I know that I must inform my prescriber immediately if I think that my partner may be pregnant while I am taking lenalidomide or within 7 days after I have stopped taking lenalidomide and my partner should be referred to a physician specialised or experienced in teratology for evaluation and advice.	Patient initials
I understand that lenalidomide will be prescribed ONLY for me. I must not share it with ANYONE.	Patient initials
I have read the lenalidomide Patient Booklet and understand the contents, including the information about other possible important health problems (side effects) associated with the use of lenalidomide.	Patient initials
I understand that I cannot donate blood while taking lenalidomide (including dose interruptions) and for at least 7 days after stopping treatment.	Patient initials
I know that I cannot donate semen or sperm while taking lenalidomide, during dose interruptions and for at least 7 days after discontinuation of lenalidomide treatment.	Patient initials
I understand that I must return any used lenalidomide capsules to my pharmacy at the end of my treatment.	Patient initials
I have been informed about which are effective contraceptive methods that my female partner can use.	Patient initials
I have been informed about the thromboembolic risk and possible requirement to take thromboprophylaxis during treatment with lenalidomide.	Patient initials

Patient Confirmation

I confirm that I understand and will comply with the requirement of the Lenalidomide Pregnancy Prevention Programme, and I agree that my prescriber can initiate my treatment with lenalidomide.

Personal data is used solely for the purpose of entering you into the Pregnancy Prevention Programme and is processed by Dr. Reddy's Laboratories, as marketing authorisation holder of pharmaceutical products and its worldwide Affiliates, to the extent and for as long as necessary, for the purposes of compliance with the Risk Management Plan legal obligations and for storage purposes.

Should you have any queries in relation to the use of your personal data please contact us at

XXX@XXX.com

Patient Signature:													Date:	DD	MM	YYYY
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