

# Pomalidomide Pharmacy Registration Form – Page 1 of 2

## Must be completed by the Chief or appointed Deputy Pharmacist (PRINT IN BLOCK CAPITALS)

Please fill in all requested information completely \*Fields are mandatory, incomplete information will result in delay.  
All Pharmacies completing and approving pomalidomide Prescription Authorisation Forms (PAFs) and/or ordering and dispensing pomalidomide are required to complete this form.

*This form is being completed by (select as appropriate)		Chief Pharmacist <input type="checkbox"/>	Deputy Pharmacist <input type="checkbox"/>
*Name of Pharmacist	First Name:	Surname:	
Pharmacist GPhC / PSNI Registration Number:			
Pharmacist Contact Details	Telephone:	E-mail:	
<b>DISPENSING PHARMACY ADDRESS</b>			
NHS Trust Name / Private Group / Other (enter full name):			
*Pharmacy Name:			
Pharmacy GPhC / PSNI Registration Number (if applicable):			
*Address line 1:			
Address line 2:			
*Town / City:	County:	*Postcode:	
*Pharmacy Contact Details	Telephone:	E-mail:	
<b>DELIVERY ADDRESS (IF DIFFERENT)</b>			
*Address line 1:			
Address line 2:			
*Town / City:	County:	*Postcode:	
<b>*PHARMACY AGREEMENT</b>			
By registering the above-named pharmacy to complete and approve PAFs and/or order and dispense pomalidomide, I agree to implement and ensure compliance with the risk minimisation measures associated with the Pregnancy Prevention Programme (PPP) for pomalidomide and adhere to the following requirements:			Select Box to Acknowledge Agreement
1. Acknowledge receipt of the pomalidomide Healthcare Professionals' Information Pack (HCPIP) (the Additional Risk Minimisation Materials (ARMMs)) provided.			<input type="checkbox"/>
2. Confirm that all pharmacists who complete and approve PAFs and/or dispense pomalidomide will have read and understood the pomalidomide HCPIP and will ensure that the pregnancy prevention measures have been implemented before dispensing pomalidomide			<input type="checkbox"/>
3. Check that each pomalidomide prescription is provided with an associated pomalidomide PAF, completed electronically via the ePPP portal or by using the paper PAF.			<input type="checkbox"/>
4. Check the PAF for completeness and/or request any missing information from the Prescriber and/or patient and complete the Dispensing Pharmacist section of the PAF, prior to dispensing pomalidomide.			<input type="checkbox"/>
5. For <b>women of childbearing potential (WCBP)</b> , check that the PAF confirms: a. the WCBP has been counselled/reminded about the teratogenic risk and has been on at least one effective method of contraception for at least 4 weeks b. the WCBP has had a negative pregnancy test within the 3 days prior to the prescription date c. the dispensing of pomalidomide is within 7 days of the prescription date d. the supply of treatment is no more than 4 weeks.			<input type="checkbox"/>
6. For <b>male patients</b> , check that the PAF confirms: a. the patient has been counselled/reminded about the teratogenic risk and the requirement to use a condom if sexually active with a pregnant woman or a WCBP not using effective contraception b. the supply of treatment is no more than 12 weeks.			<input type="checkbox"/>
7. For <b>women not of childbearing potential (WNCBP)</b> , check the supply of treatment is no more than 12 weeks.			<input type="checkbox"/>
8. For pharmacies not completing PAFs via the ePPP, a copy of each completed paper PAF must be sent to Accord immediately after each pomalidomide prescription is dispensed. Pharmacies should retain the original paper PAF at the pharmacy premises for a minimum of 2-years.			<input type="checkbox"/>
9. Should an institution utilise its own electronic systems (or paper PAF) to implement the risk minimisation measures associated with the PPP, ensure that all data fields at a minimum, correspond to those that are included in the Accord PAF. Justification for use, together with the proposed PAF should be provided to Accord for review and subsequent approval by the MHRA. <b>A copy of each completed PAF must be sent immediately to Accord.</b>			<input type="checkbox"/>
10. Ensure on receipt of pomalidomide, it is only dispensed to the patient by the pharmacy registered with Accord, to fulfil the requirements of the PPP for pomalidomide. <b>Wholesaling is strictly prohibited.</b>			<input type="checkbox"/>
11. Notify Accord <b>immediately</b> of changes in Chief Pharmacist or appointed Deputy Pharmacist, including their corresponding contact details in order to ensure appropriate registration of the pharmacy to order and dispense Pomalidomide.			<input type="checkbox"/>

## Pomalidomide Pharmacy Registration Form – Page 2 of 2

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### \*PHARMACIST DECLARATION

- |    |   |                          |
|----|---|--------------------------|
| 1. | I acknowledge this registration to complete and approve PAFs and/or order and dispense pomalidomide is valid for 2 years only, after which I am required to re-register the above-named pharmacy, should I wish to continue to complete and approve PAFs and/or order and dispense pomalidomide.                | <input type="checkbox"/> |
| 2. | I understand during the period of registration, if I am unable to fulfil requirements 1-11, the above named-pharmacy will be de-registered by Accord. I will be unable to order any further pomalidomide and required to go through the registration process again, following any necessary remedial action(s). | <input type="checkbox"/> |
| 3. | I understand that my personal data will be processed by Accord, for the purposes of administering the PPP for pomalidomide.   | <input type="checkbox"/> |
| 4. | I understand the information supplied to Accord on PAFs will be used to provide anonymised aggregate annual reports to the Medicines and Healthcare products Regulatory Agency (MHRA) to assess the implementation of the PPP.  | <input type="checkbox"/> |

**\*Pharmacist Signature:**

**\*Signature Date:**

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Healthcare professionals are asked to report any suspected adverse reactions using the Yellow Card Scheme via <https://yellowcard.mhra.gov.uk/> or by searching for MHRA Yellow Card in the Google Play or Apple App Store. Adverse reactions should also be reported to Accord Medical Information on 01271 385257 or [medinfo@accord-healthcare.com](mailto:medinfo@accord-healthcare.com)

**Email the completed forms to Accord at [rmpteam@accord-healthcare.com](mailto:rmpteam@accord-healthcare.com), alternatively fax the forms to 01271 346106**