Nottingham City Hospital NHS
NHS Trust

PRESCRIPTION FOR THALIDOMIDE

PATIENT IN MYELOMA IX STUDY YES……NO…….

Patient details (Affix addressograph label)

Please indicate (TICK);
INITIAL PRESCRIPTION **……**
Actions required;
Register and consent patient
Patient to complete telephone survey ……
Prescriber to complete telephone survey ……
and obtain authorisation number for prescription ……

SUBSEQUENT PRESCRIPTION **……**
Actions Required;
Patient to complete telephone survey …….
Prescriber to complete telephone survey …….
And obtain authorisation number for prescription …….

Please dispense the following ;

THALIDOMIDE ……mg DAILY for days (max 28 days)
(Each pack 50mg x 28 capsules)
PHARMACIST INSTRUCTIONS;

Before dispensing
Call the IVRS at the Pharmion Risk Management Centre 0808 156 3057 and enter;
Pharmacy ID number (……)
Authorisation number from the prescription
Number of capsules to be dispensed (dispense in outers of 28 DO NOT SPLIT PACKS UNLESS PATIENT ON INTENSIVE ARM OF MYELOMA IX STUDY IN WHICH CASE 3 WEEK COURSE GIVEN- NB INCLUDE PIL AND LABEL'Follow printed instructions')
Record the confirmation number allocated by IVRS here ……
Dispense and record on named patient record form

DO NOT DISPENSE MORE THAN 28 DAYS SUPPLY ON ANY PRESCRIPTION.
FOR SUBSEQUENT PRESCRIPTIONS DISPENSE ONLY IF FEWER THAN 7 DAYS OF THERAPY REMAIN ON THE PREVIOUS PRESCRIPTION (check records to verify this)

Prescribers signature: _____Date: _____
Prescribers Name: _____
Pharmacy use only
Dispensed by: _____ Checked by: _____Date: _____