



K.S. KIM INTERNATIONAL

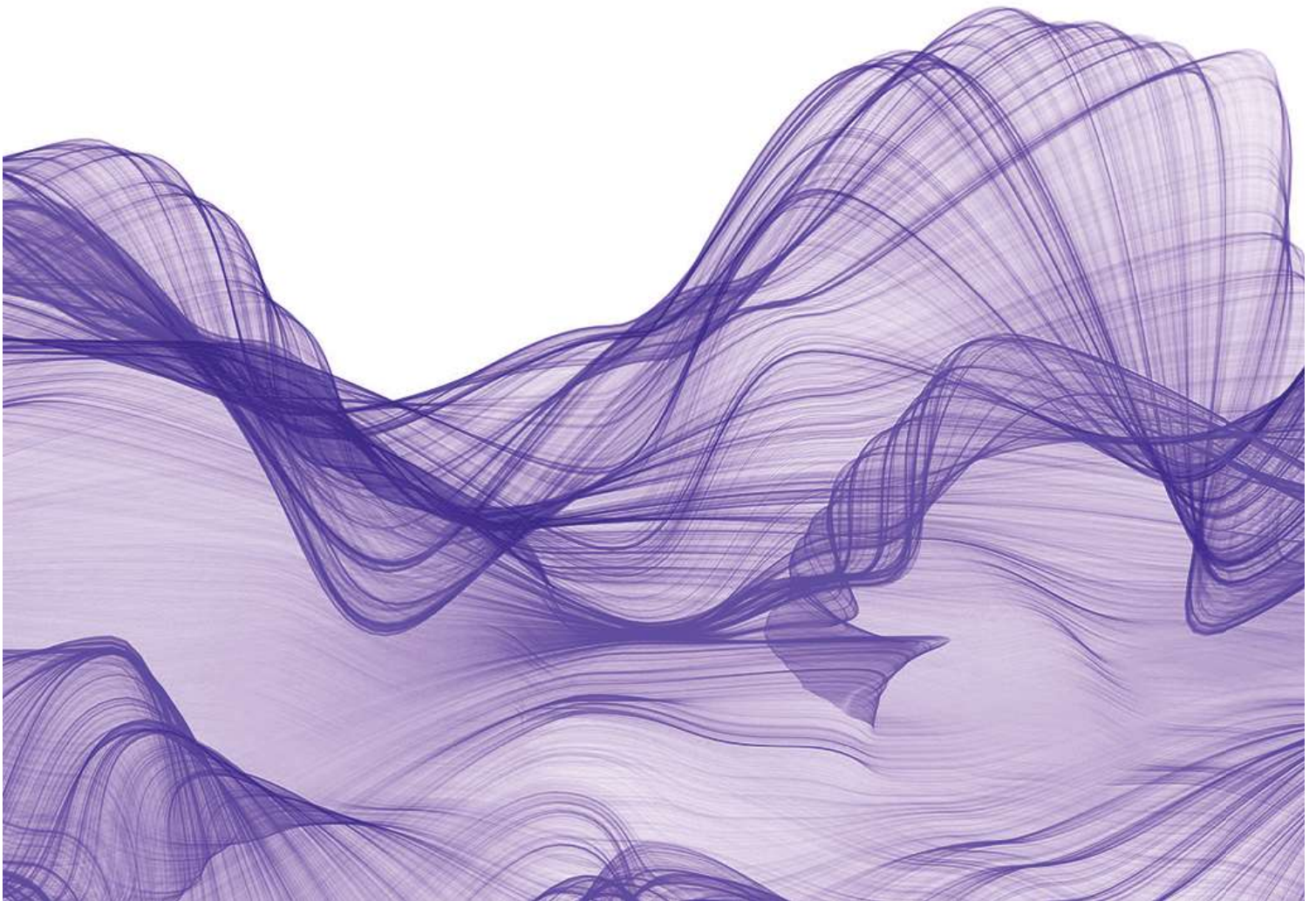
Patient Registration Form

Lenalidomide S.K.

RMP- Risk Management Plan

PPP- Pregnancy Prevention

Please send this signed form to K.S. Kim International Ltd.
lenalidomide@sk-pharma.com



Patient Registration Form

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Please send this signed form to K.S. Kim International Ltd.: lenalidomide@sk-pharma.com

Patient Details:

Initials: _____ ID Number: _____ Sex: _____

Date of Birth: ____/____/____ (Day/Month/Year)

Sick Fund: _____

Indication of Lenalidomide S.K.

Fertility Status:

☐ Male

☐ Female of Childbearing Potential

☐ Female not of Childbearing Potential

☐ Under the age of 18

Doctor's details enrolling the patient for the Lenalidomide S.K. RMP.

Name of Doctor: _____ Licence Number: _____

Name of Medical Institution & City

Phone Number: _____

Email address: _____

Doctor's Declaration

I declare that prior to the first prescription, the above-mentioned patient has been counselled on the risks of teratogenicity resulting from use of the drug and the need to avoid pregnancy.

Date of negative pregnancy tests before starting treatment: [☐ Check **ONLY** if **not** relevant]

(There must be no more than **3 days** between the dates of the last negative pregnancy test and the prescription)

____/____/____ (Day/Month/Year)

For Female Patients: I declare that this patient has been assessed and according to the requirements in the risk management programme, **this patient CANNOT get pregnant, therefore she is exempt from preforming monthly pregnancy tests.** ☐ (ONLY CHECK IF APPLICABLE)

Doctors Name: _____ Licence Number: _____

Signature & Stamp of Doctor:

____/____/____ (DD/MM/YYYY)

Patient Declaration:

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I confirm that I received and read all the safety information regarding Lenalidomide S.K. including the "Patient Information Booklet." I also confirm that my doctor has explained all the risks involved in Lenalidomide S.K. treatment according to the Risk Management Plan.

I agree to take all necessary precautions to prevent exposure of a foetus to Lenalidomide S.K. in accordance with the requirements of the Ministry of Health.

I agree that my personal information, will be stored in a database managed by the Marketing Authorisation Holder "K.S. Kim International Ltd." in accordance with the Privacy Protection Law, and I have read and agree to the terms stated within "Personal Information."

For women: I confirm that I am not pregnant and do not plan to conceive during the treatment period.

ID Number: _____

Initials: _____ Signature _____ Date: ____/____/____

Parent/Guardian Declaration

I confirm that we have received and read all the safety information regarding Lenalidomide S.K. including the "Patient Information Booklet." I also confirm that the patient's doctor has explained all the risks involved in Lenalidomide S.K. treatment according to the Risk Management Plan.

I agree to take all necessary precautions possible to prevent exposure of a foetus to Lenalidomide S.K., in accordance with the requirements of the Ministry of Health.

I agree that the personal information, will be stored in a database managed by the Marketing Authorisation Holder "K.S. Kim International Ltd." in accordance with the Privacy Protection Law, and I have read agree to the terms stated within "Personal Information."

For Female Patients: I confirm that the patient under my responsibility is not pregnant and is not planning to conceive during the treatment period.

Patient

Initials: _____

ID Number: _____

Parent/Guardian

Full Name _____

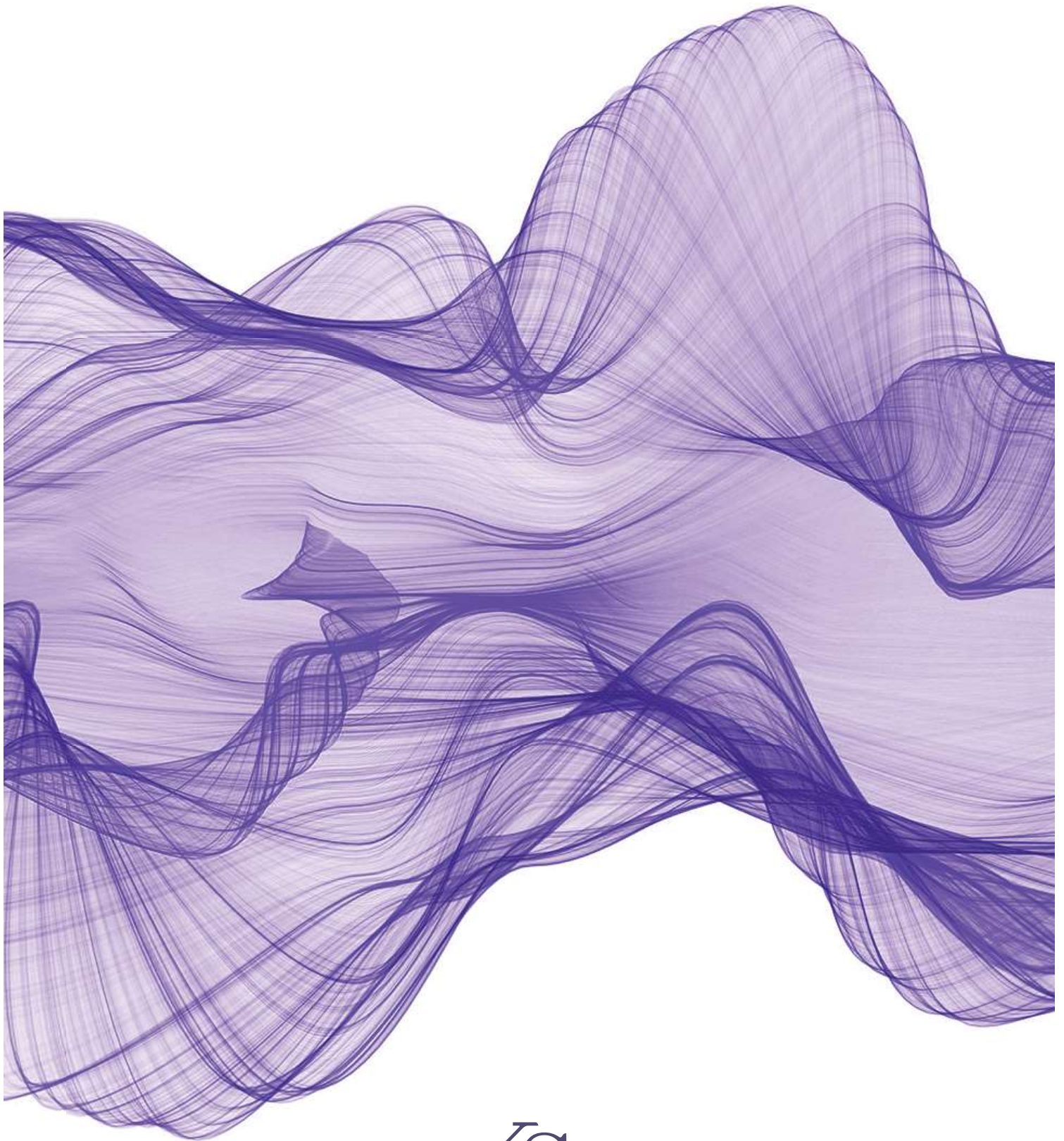
ID Number: _____

Date: ____/____/____

Signature _____

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www.sk-pharma.com