K.S. KIM INTERNATIONAL

Pharmacy Registration Form

To be completed and signed by the Responsible Pharmacist

1) I acknowledge that I have received, read and understood all the information packages in relation to the Lenalidomide S.K. Risk Management Program, which include the Healthcare Professional and Patient's Information Booklet.

2) I have read and understand the principles of Lenalidomide S.K. Risk Management Program and I will work to prevent teratogenic risk in accordance with the Ministry of Health requirements.

3) I will ensure that, for women of childbearing potential, dispensing of Lenalidomide S.K. will only be performed with a Doctor's approved negative pregnancy test results provided on "Monthly Pregnancy Test Form" and I will share this, together with the prescription, to K.S. Kim for approval.

4) I will ensure that Lenalidomide S.K., for a patient of childbearing potential, will only be dispensed within 7 days of her last medically supervised **negative** pregnancy test.

5) I will send to KS Kim a copy of the prescription together with the results from the medically signed pregnancy test, **before** dispensing or supplying Lenalidomide S.K.

6) I understand that I can only supply a 4-week course of Lenalidomide S.K.

7) I have read "Storage of Personal Information" relating to the administration of the drug Lenalidomide S.K., I also agree that the personal information, as set out in this form, will be stored in a database managed by the registration owner, K.S. Kim International Ltd. in accordance with the Privacy Protection Law.

8) I, as the Responsible Pharmacist, ensure that all Pharmacists that work in my institution will receive all the information packages in relation to the Lenalidomide S.K. Risk Management Program, which include the Healthcare Professionals Information Pack & Patient Information Pack and I will ensure their understanding regarding the Risk Management Plan (RMP) and the restrictions regarding supply and dispensing of Lenalidomide S.K.

9) I am the Responsible Pharmacist for the below stated institution, and I agree to these terms on behalf of the institution. In the event that the Responsible Pharmacist changes for the below institution, I, together with the newly appointed Responsible Pharmacist, are obliged to inform K.S. Kim of this change by re-registering using this form.

Name: _____ Registration Number: _____

Name of Healthcare Institution & City:

_____,_____

Contact Number: Email Address:

_____ _____

Signature & Stamp:

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

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