Thalidomide BMS® (thalidomide) Order Form Ireland

Orders cannot be processed unless this form is fully completed and signed. The completed Order Form should be emailed to United Drug Distribution (UDD), for the attention of UDD Customer Service **SpecialOrders@united-drug.com** or **Faxed to 01 463 2404**. Orders received before **13:30 Monday-Friday** will be delivered the next working day (note there are no deliveries on Saturdays).

For queries about your order please email **SpecialOrders@united-drug.com** or **Telephone 01 463 2478.** Please ensure all data is recorded in Black or Blue ink. Prescription Authorisation Forms and Prescriptions should not be sent to United Drug.

Pharmacy Details

Ordered by: (Please print full name and position e.g. Irish registered pharmacist/technician)

Pharmacy Name & address: (Please print)

Pharmacy Stamp

Pharmacy Telephone:

Please indicate your nominated Wholesaler: (Please tick)

UD	☐ Dublin	☐ Ballina	☐ Limerick

UD Wholesale Account Number:

Patient Details

Prescriber (Please print)

Treating Hospital

Indication

Patient Date of Birth

Male	TICK
Woman of childbearing potential (WCBP)	TICK
Woman of non-childbearing potential (WNCBP)	TICK

Dose of thalidomide being prescribed

Date of prescription

Product Description	Strength	Quantity required
Thalidomide BMS® Capsules	50mg	

Comments

Is this the 1st, 2nd or 3rd dispensing of this prescription: 1st ☐ 2nd ☐ 3rd ☐

Total Supply Prescribed: 4-weeks ☐ 8-weeks ☐ 12-weeks ☐ Other - specify_____

I confirm that I am ordering on behalf of a registered pharmacy and that thalidomide will be dispensed in accordance with the risk minimisation procedures for thalidomide, as specified by BMS in the Thalidomide BMS® Healthcare Professionals' Information Pack.

I confirm that treatment lengths will be limited to a maximum 4 weeks supply for women of childbearing potential and a maximum of 12 weeks for males and women of non-childbearing potential patients. For women of childbearing potential dispensing will be within 7 days of the date of prescription

Sign

Date

Telephone

Print

FOR INTERNAL USE ONLY:

Sales Order:_____ Date: _____ Initials: _____