EU RISK MANAGEMENT PLAN for

POMALIDOMIDE TEVA
(POMALIDOMIDE)

RMP version to be assessed as part of this application	
RMP version number	2.0
Data lock point for this RMP	28 February 2026
Date of final sign off	31 March 2026
Rationale for submitting an updated RMP	Alignment with Imnovid's (MAH: Bristol-Myers Squibb EEIG) RMP v18.0, published on EMA website on 20 January 2026.

QPPV Details	
QPPV name:	Iva Novak
QPPV oversight declaration:	The content of this RMP has been reviewed and approved by the marketing authorisation holder´s QPPV/deputy. The electronic signature is available on file.

Table 1: Summary of Significant Changes in This RMP Version

RMP part/module	Part/module version number and date of approval (opinion date)	High level description of major changes
Part I Product(s) overview	v1.2 (14 November 2024)	Section revised with minor administrative changes in line with GVP Module V Revision 2.0.1 RMP template requirements.
Part II - Module SI Epidemiology of the indication(s) and target population(s)	v1.2 (14 November 2024)	Not applicable.
Part II - Module SII Non-clinical part of the safety specification	v1.2 (14 November 2024)	Not applicable.
Part II - Module SIII Clinical trial exposure	v1.2 (14 November 2024)	Not applicable.
Part II - Module SIV Populations not studied in clinical trials	v1.2 (14 November 2024)	Not applicable.
Part II - Module SV Post-authorisation experience	v1.2 (14 November 2024)	Not applicable.
Part II - Module SVI Additional requirements for the safety specification	v1.2 (14 November 2024)	Not applicable.
Part II - Module SVII Identified and potential risks	v1.2 (14 November 2024)	Not applicable.
Part II - Module SVIII Summary of the safety concerns	v1.2 (14 November 2024)	Section revised to add reference to the latest reference medicinal product's RMP.
Part III Pharmacovigilance plan (including post-authorisation safety studies)	v1.2 (14 November 2024)	Not applicable.
Part IV Plans for post-authorisation efficacy studies	v1.2 (14 November 2024)	Not applicable.
Part V Risk minimisation measures (including evaluation of the effectiveness of risk minimisation activities)	v1.2 (14 November 2024)	Not applicable.

RMP part/module	Part/module version number and date of approval (opinion date)	High level description of major changes
Part VI Summary of the risk management plan	v1.2 (14 November 2024)	Section revised to add reference to the latest reference medicinal product's RMP.
Part VII Annexes	v1.2 (14 November 2024)	Annex 6: Pregnancy Reporting Form was removed from the Educational Healthcare Professional's Kit Annex 8 added.

Details of the currently approved RMP	
Version number	v1.2
Approved with procedure	EMEA/H/C/006302
Date of approval (opinion date)	14 November 2024

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Absolute Neutrophil Count
AFP	Alpha-Fetoprotein
APTT	Activated Partial Thromboplastin Clotting Time
ARMM	Additional Risk Minimisation Activity
ATC	Anatomical Therapeutic Chemical
BNP	Brain Natriuretic Peptide
CBC	Complete Blood Count
CHMP	Committee for Medicinal Products for Human Use
CK-MB	Creatine Kinase-MB
COPD	Chronic Obstructive Pulmonary Disease
CPK	Creatine Phosphokinase
CT	Computed Tomography
DNA	Deoxyribonucleic Acid
EBV	Epstein-Barr Virus
ECG	Electrocardiogram
e.g.	example given
EPAR	European Public Assessment Report
ESR	Erythrocyte Sedimentation Rate
EU	European Union
EURD	European Union Reference Dates
FAP	Familial Adenomatous Polyposis
GERD	Gastroesophageal Reflux Disease
GVP	Good Pharmacovigilance Practices
HCP	Healthcare Professional
HIV	Human Immunodeficiency Virus
HLT	High Level Term
HPV	Human Papilloma Virus
INN	International Non-proprietary Name
INR	International Normalised Ratio
IV	Intravenous
LFT	Liver Function Test
LMP	Last Menstruation Period
LPRD	Laryngopharyngeal Reflux Disease

LSO	Local Safety Officer
MAH	Marketing Authorisation Holder
MDS	Myelodysplastic Syndromes
MedDRA	Medical Dictionary for Regulatory Activities
MM	Multiple Myeloma
NCA	National Competent Authority
NK	Natural Killer
NMSC	Non-Melanoma Skin Cancer
NSAID	Nonsteroidal Anti-Inflammatory Drugs
PIN	Prostatic Intraepithelial Neoplasia
PL	Package Leaflet
PPP	Pregnancy Prevention Programme
PT	Preferred Term
PT	Prothrombin Time
RBC	Red Blood Cell
RMP	Risk Management Plan
SmPC	Summary Of Product Characteristics
SMQ	Standardised MedDRA Query
SOC	System Organ Class
SPM	Second Primary Malignancy
UV	Ultraviolet
VHL	von Hippel-Lindau
WBC	White Blood Cell
WCBP	Women of Childbearing Potential

Part I: Product(s) Overview

Table 2: Product(s) Overview

Active substance(s) (INN or common name)	**Pomalidomide**
Pharmacotherapeutic group(s) (ATC Code)	Other Immunosuppressants (L04AX06)
Marketing Authorisation Holder/Applicant	TEVA GmbH
Medicinal products to which this RMP refers	1
Invented name(s) in the European Economic Area (EEA)	Pomalidomide Teva 1 mg hard capsules Pomalidomide Teva 2 mg hard capsules Pomalidomide Teva 3 mg hard capsules Pomalidomide Teva 4 mg hard capsules
Marketing authorisation procedure	Centralised
Brief description of the product	**Chemical class**: Thalidomide analogue
	Summary of mode of action: Pomalidomide is an analog of thalidomide with tumouricidal, immunomodulatory, anti-angiogenic, and anti-inflammatory properties. The multiple pharmacological properties of pomalidomide suggested a potential therapeutic benefit in patients with multiple myeloma (MM). The activity of pomalidomide, and other immunomodulatory compounds, is exerted through binding to cereblon, a component of an E3 ligase complex that includes deoxyribonucleic acid (DNA) damage-binding protein 1, cullin 4, and Rocl. In the presence of pomalidomide in vitro, substrate proteins Aiolos and Ikaros are targeted for ubiquitination and subsequent degradation leading to direct anti-myeloma cytotoxic and immunomodulatory effects. Pomalidomide enhanced T cell- and natural killer cell- mediated immunity and inhibited production of pro-inflammatory cytokines (eg, tumor necrosis factor alpha and interleukin 6) by monocytes. Additionally, pomalidomide retained activity in lenalidomide-resistant MM cell lines, despite reduced cereblon expression. In vivo, pomalidomide therapy reduced the levels of lkaros in patients with relapsed, lenalidomide-refractory MM.
	Important information about its composition: Not applicable.

Hyperlink to the Product Information	Please refer to CTD Module 1.3.1.
Indication(s) in the EEA	**Current**: Pomalidomide Teva in combination with bortezomib and dexamethasone is indicated in the treatment of adult patients with multiple myeloma who have received at least one prior treatment regimen including lenalidomide. Pomalidomide Teva in combination with dexamethasone is indicated in the treatment of adult patients with relapsed and refractory multiple myeloma who have received at least two prior treatment regimens, including both lenalidomide and bortezomib, and have demonstrated disease progression on the last therapy.
	Proposed (if applicable): Not applicable.
Dosage in the EEA	**Current**: Pomalidomide treatment should be initiated and monitored under the supervision of physicians experienced in the management of multiple myeloma. *Pomalidomide in combination with bortezomib and dexamethasone* The recommended starting dose of pomalidomide is 4 mg taken orally once daily on Days 1 to 14 of repeated 21-day cycles. The recommended starting dose of bortezomib is: • For Cycles 1 to 8: 1.3 mg/m2/dose IV or SC on Days 1, 4, 8 and 11 of a 21-day cycle. • For Cycle 9 and onwards: 1.3 mg/m2/dose IV or SC on Days 1 and 8 of a 21-day cycle. The recommended dose of dexamethasone is: • For Cycles 1 to 8: 20 mg/day (≤ 75 years old) or 10 mg/day (> 75 years old) taken orally on Days 1, 2, 4, 5, 8, 9, 11 and 12 of a 21-day cycle. • For Cycle 9 and onwards: 20 mg/day (≤ 75 years old) or 10 mg/day (> 75 years old) taken orally on Days 1, 2, 8 and 9 of a 21-day cycle. Treatment with pomalidomide combined with bortezomib and dexamethasone should be given until disease progression or until unacceptable toxicity occurs. *Pomalidomide in combination with dexamethasone* The recommended starting dose of pomalidomide is 4 mg taken orally once daily on Days 1 to 21 of each 28-day cycle. The recommended dose of dexamethasone is 40 mg orally once daily on Days 1, 8, 15 and 22 of each 28-day treatment cycle.

	Treatment with pomalidomide combined with dexamethasone should be given until disease progression or until unacceptable toxicity occurs.
	Proposed (if applicable): Not applicable.
Pharmaceutical form(s) and strengths	**Current**: 1 mg, 2 mg, 3 mg and 4 mg hard capsules
	Proposed (if applicable): Not applicable.
Is/will the product be subject to additional monitoring in the EU?	No

Part II: Safety Specification

Part II: Module SI - Epidemiology of the Indication(s) and Target Population(s)

Not applicable.

Part II: Module SII - Non-Clinical Part of the Safety Specification

Not applicable.

Part II: Module SIII - Clinical Trial Exposure

Not applicable.

Part II: Module SIV - Populations Not Studied in Clinical Trials

Not applicable.

Part II: Module SV - Post-Authorisation Experience

Not applicable.

Part II: Module SVI - Additional EU Requirements for the Safety Specification

Not applicable.

Part II: Module SVII - Identified and Potential Risks

Not applicable.

Part II: Module SVIII - Summary of the Safety Concerns

Table 3: Summary of Safety Concerns

Summary of safety concerns	
Important identified risks	• Teratogenicity • Severe infection due to neutropenia and pancytopenia • Thrombocytopenia and bleeding • Cardiac failure • Non-melanoma skin cancer
Important potential risks	• Other second primary malignancies • Cardiac arrhythmia
Missing information	• None

The summary of safety concerns is aligned the list of safety concerns in the originator's (Imnovid®, Bristol-Myers Squibb EEIG) RMP v18.0, published on EMA website on 20 January 2026.

Part III: Pharmacovigilance Plan (Including Post-Authorisation Safety Studies)

III.1 Routine Pharmacovigilance Activities

An Analysis of Adverse Drug Reactions of Special Interest within the Required PSURs

Data regarding pregnancy exposure to pomalidomide are targeted for review and specifically discussed in the PSUR document. These data include all pregnancy case reports collected during the specified period together with cumulative data. Non-medically confirmed case reports of suspected foetal exposure are also provided, whenever applicable. Non-patient exposure in pregnant females (eg, a nurse opening the capsules, laboratory technician, or carer) is also provided with the corresponding outcome in each PSUR.

Routine pharmacovigilance activities beyond adverse reactions reporting and signal detection:

- Specific adverse reaction follow-up questionnaires:

For events of special interest, materials and tools (such as event-specific questions) have been developed to ensure that consistent and good quality follow-up information can be obtained. Event-specific questionnaires are used to collect adverse reaction and follow-up information for all of the important identified and potential risks. These forms are provided in Annex 4 – Specific Adverse Drug Reaction Follow-Up Forms of the RMP.

Other forms of routine pharmacovigilance activities:

- Expedited Reporting and Follow-up of Pregnancy

The pregnancy capture and follow-up procedure is detailed below.

The PPP aims to minimise the risks of teratogenicity by ensuring HCPs and patients are fully informed of and understand the risks of teratogenicity prior to starting their pomalidomide treatment. Like lenalidomide, pomalidomide is an immunomodulatory agent with expected teratogenic effects in humans. Therefore, the core PPP for pomalidomide is based on the EU and EEA approved core PPP for lenalidomide. It reflects advice, guidance and direction obtained from the Member States during the implementation process for lenalidomide. Where possible and with the agreement of the NCA, Teva harmonised the pomalidomide PPP with the already implemented lenalidomide PPP in each Member State. In order to ensure there is a consistent approach with the ability to capture all information globally, the same principles on obtaining follow-up data on pregnancies are implemented in all territories where pomalidomide is marketed whilst taking into account the legal and healthcare differences in those territories worldwide.

The objectives of the system are:

- To obtain information on all reported pregnancies of females exposed to pomalidomide.
- To obtain information on all reported pregnancies of female partners of male patients exposed to pomalidomide.

- To determine the root cause of all pregnancies and hence failures of the PPP.

In the EU, Teva uses the following method to enhance the capture of reports of pregnancy over and above reliance upon spontaneous reporting:

- The Educational Materials in the Educational HCP's Kit make reference to the requirement to report all suspected pregnancies to the local Teva office and where applicable to the NCA. The Patient Brochure also advises the patient to immediately seek medical advice if there is any risk or suspicion of possible pregnancy. Similar advice is also provided with reference to female partners of male patients.

Database of Pregnancy Reports

All reports of pregnancies received by Teva are entered into Teva Global Safety Database. This includes all Consumer reports in addition to HCP reports. Any abnormal pregnancy test result (eg, β-hCG elevated and positive urine pregnancy test) is immediately processed. EU Health Authorities are notified of these reports.

Follow-up

All reports of pregnancies are followed up. Follow-up is via the reporter as appropriate. In each country office, any report of pregnancy is followed up by the Local safety officer. All reports of pregnancy are also immediately notified to the QPPV and QPPV deputies. All reports of abnormal pregnancy test results are followed up with the prescriber and follow-up information sent to Health Authorities.

Frequency/Duration of Follow-up

Upon receipt of a notification of pregnancy, the HCP is asked to complete the Initial Pregnancy Report Form. The Initial Pregnancy Report Form includes a field for Estimated Date of Delivery. Upon receipt of this information by Teva, dates for further follow-up actions are tracked. The HCP/Obstetrician is also sent a Follow-Up and Outcome Form to be completed at the outcome of the Pregnancy. An Infant follow-up form is available for use in the event that a birth defect is detected as an outcome.

Corresponding standard forms are available on request.

Root Cause of Failure of Pregnancy Prevention Programme

The Pregnancy Background Form includes questions to determine why the PPP was unsuccessful for the case in question.

Regulatory Reporting of Pregnancies

All initial pregnancy reports and follow-up information are reported on an expedited basis within 15 days.

Should any suspected teratogenic effect be reported following treatment with pomalidomide, this is expedited immediately.

Compliance with the PPP is monitored in each member state. Examples of methods to monitor compliance include keeping a record of counselling patients prior to prescription, a record of a negative pregnancy test within 3 days of prescription and a record of dispensing within 7 days of

the prescription date, etc. The maximum interval of consecutive PPP compliance studies is agreed on between Teva and individual NCAs.

III.2 Additional Pharmacovigilance Activities

Study short name and the title: Monitoring of implementation of PPP

Rationale and study objectives: Monitoring of implementation of PPP

Study design: The monitoring of the implementation of the PPP (category 3 study) will be agreed on a country-specific basis with the relevant National Competent Authority (NCA) in accordance with legal local framework. Methods are anticipated to be similar to the activities in place for the reference medicinal product. Moreover, data will be collected on a regular basis after product launch and the results will be reported in PSURs, in accordance with the PSUR schedule.

Study population: patients in The EU receiving Pomalidomide

Milestones: Routine PSURs in line with DLP of the latest EURD List

III.3 Summary Table of Additional Pharmacovigilance Activities

Table 4: Ongoing and Planned Additional Pharmacovigilance Activities

Activity and status	Summary of objectives	Safety concerns addressed	Milestones	Due dates
Category 3 – Required additional pharmacovigilance activities				
Monitoring of pregnancy prevention programme (PPP) Ongoing	Monitoring of implementation of PPP	Teratogenicity	Routine PSURs in line with DLP of the latest EURD-List.	Data will be reviewed on an ongoing basis as part of signal detection and reported within PSURs in line with EURD-List.

Part IV: Plans for Post-Authorisation Efficacy Studies

Not applicable.

Part V: Risk Minimisation Measures (Including Evaluation of the Effectiveness of Risk Minimisation Activities)

Risk Minimisation Plan

V.1. Routine Risk Minimisation Measures

Table 5: Description of Routine Risk Minimisation Measures by Safety Concern

Safety concern	Routine risk minimisation measures
IMPORTANT IDENTIFIED RISKS	
Teratogenicity	**Routine risk communication:** Risk is listed in SmPC section 4.8. Described in PL section 2. **Routine risk minimisation measures recommending specific clinical measures to address the risk:** Risk is listed in Section 4.3, 4.4, 4.6 and 5.3 of the SmPC where specific guidance is given. **Other routine risk minimisation measures beyond the Product Information:** Legal status: restricted medical prescription.
Severe infection due to neutropenia and pancytopenia	**Routine risk communication:** Risk is listed in SmPC section 4.8. Described in PL section 2 and 4. **Routine risk minimisation measures recommending specific clinical measures to address the risk:** Risk is listed in SmPC section 4.2 where dose reduction advice for neutropenia is given. Risk is listed in SmPC section 4.4 where advice for blood testing is provided. **Other routine risk minimisation measures beyond the Product Information:** Legal status: restricted medical prescription.
Thrombocytopenia and bleeding	**Routine risk communication:** Risk is listed in SmPC section 4.8. Described in PL section 2 and 4. **Routine risk minimisation measures recommending specific clinical measures to address the risk:** Risk is listed in SmPC section 4.2 where advice for dose reduction advice for thrombocytopenia is given. Risk is listed in SmPC section 4.4 where advice for blood testing is provided. **Other routine risk minimisation measures beyond the Product Information:** Legal status: restricted medical prescription.
Cardiac failure	**Routine risk communication:** Risk is listed in SmPC section 4.8. Described in PL sections 2 and 4. **Routine risk minimisation measures recommending specific clinical measures to address the risk:**

Safety concern	Routine risk minimisation measures
	Risk is listed in SmPC section 4.4 where advice for periodic monitoring for signs or symptoms of cardiac events is provided. **Other routine risk minimisation measures beyond the Product Information:** Legal status: restricted medical prescription.
Non-melanoma skin cancer	**Routine risk communication:** Risk is listed in SmPC section 4.8. Described in PL section 2 and 4. **Routine risk minimisation measures recommending specific clinical measures to address the risk:** Risk is listed in SmPC section 4.4 where advice for standard cancer screening is provided. **Other routine risk minimisation measures beyond the Product Information:** Legal status: restricted medical prescription.
IMPORTANT POTENTIAL RISKS	
Other second primary malignancies	**Routine risk communication:** Risk is listed in SmPC section 4.4 and 5.3. Described in PL section 2. **Routine risk minimisation measures recommending specific clinical measures to address the risk:** Risk is listed in SmPC section 4.4 where advice for standard cancer screening is provided. **Other routine risk minimisation measures beyond the Product Information:** Legal status: restricted medical prescription.
Cardiac arrhythmias	**Routine risk communication:** Risk is listed in SmPC sections 4.8. Described in PL section 4. **Routine risk minimisation measures recommending specific clinical measures to address the risk:** None. **Other routine risk minimisation measures beyond the Product Information:** Legal status: restricted medical prescription.
MISSING INFORMATION	
None	

V.2. Additional Risk Minimisation Measures

Table 6: Pregnancy Prevention Programme (PPP)

Objectives	To minimise the risk of teratogenicity by: • Ensuring that exposure of an unborn child to pomalidomide does not occur • Ensuring early alert to the physician of any pregnancies • Educating patients and HCPs on the safe use of pomalidomide • Pregnancy testing and contraceptive requirements • A system to ensure that all appropriate measures have been performed prior to the drug being dispensed • Managing and monitoring the distribution of pomalidomide • Follow-up on the effectiveness of the PPP • Compliance monitoring and assessment (examples include record of counselling patients prior to prescription, record of negative pregnancy test within 3 days of prescription and record of dispensing within 7 days of prescription date). This controlled access is designed to minimise the risk of exposure to paediatric patients or non-target populations and provide education on the risk and the necessary steps to prevent foetal exposure.
Rationale for the additional risk minimisation activity	Pomalidomide is teratogenic in animals and is expected to be teratogenic in humans. To minimise the risk of teratogenicity and provide education on the risk and necessary steps to prevent foetal exposure to pomalidomide.
Target audience and planned distribution path	Healthcare Professionals (HCPs) expected to prescribe pomalidomide and patients using it. <u>Proposed Actions</u> The key elements of the PPP are: • Educational Programme: Educational HCP's kit to include educational healthcare professional brochure, educational brochures for patients, patient card, risk awareness forms, and information on where to find latest SmPC. • Therapy management, • Prescribing controls, • Dispensing controls, • Assessment. The Patient Card and/or an equivalent tool is used to manage the controlled access within the national territory as agreed with the NCA.
Plans to evaluate the effectiveness of the interventions and criteria for success	Compliance with the PPP will be monitored in each member state in agreement with the relevant NCA (eg, record of counselling patients prior to prescription, record of a negative pregnancy test within 3 days of prescription and a record of dispensing within 7 days of the prescription date, etc). Proposed Review Period The PPP will be analysed on an ongoing basis and summarised at the time of the PSUR with respect to any pregnancy exposures. Additional information to be provided in the updates include:

	• Status of the implementation in each Member State. • Any adaptations to the PPP will be included as an update. • The results of any compliance measurements as process indicators undertaken in individual countries according to country specific agreements with NCAs. • Reports of pregnancy exposure to be reviewed on an ongoing basis and summarised at the time of the PSUR overall and by country. • Root causes for pregnancy exposure. • Outcome of pregnancy. • Modifications and corrective action will be taken accordingly. Criteria for Success Outcome indicator: pregnancy exposures

Table 7: The Educational Healthcare Professional's Kit

- Educational healthcare professional brochure
- Information on where to find latest SmPC

Objectives	To inform HCPs of risks of Teratogenicity, Thrombocytopenia and bleeding, Cardiac failure.
Rationale for the additional risk minimisation activity	HCPs to understand the risks specified above and the appropriate management of these risks.
Target audience and planned distribution path	HCPs expected to prescribe pomalidomide and pharmacists.
Plans to evaluate the effectiveness of the interventions and criteria for success	The success of proposed additional risk minimization activities will be measured by routine pharmacovigilance: • Expedited reporting (evaluation plus reporting [E+R]) as per EU guidance, GVP, • PSUR as per EU guidance, GVP (E+R). Criteria for Success No significant increase in frequency of reports in the post-marketing setting as presented in the SmPC. Planned Dates for Assessment Next PSUR update with next data-lock point covered.

Table 8: Educational Brochures for Patients

Objectives	To inform patients of risk of Thrombocytopenia and bleeding.
Rationale for the additional risk minimisation activity	A Pomalidomide Patient brochure is provided as additional educational material to advise that pomalidomide may cause thrombocytopenia and the need for regular blood tests.
Target audience and planned distribution path	Patients using pomalidomide.
Plans to evaluate the effectiveness of the interventions and criteria for success	The success of proposed additional risk minimization activities will be measured by routine pharmacovigilance: • Expedited reporting (E+R) as per EU guidance, GVP, • PSUR as per EU guidance, GVP (E+R). Criteria for Success No significant increase in frequency of reports in the post-marketing setting as presented in the SmPC. Planned Dates for Assessment Next PSUR update with next data-lock point covered.

V.3. Summary of Risk Minimisation Measures

Table 9: Summary Table of Pharmacovigilance Activities and Risk Minimisation Activities by Safety Concern

Safety concern	Risk minimisation measures	Pharmacovigilance activities
IMPORTANT IDENTIFIED RISKS		
Teratogenicity	**Routine risk minimisation measures:** SmPC sections 4.3, 4.4, 4.6, 4.8 and 5.3. PL section 2. Legal status. **Additional risk minimisation measures:** Pregnancy Prevention Programme: 1. Educational Programme consisting of: a. The Educational Healthcare Professional's Kit to include educational healthcare professional brochure, educational brochures for patients, patient card, risk awareness	**Routine pharmacovigilance activities beyond adverse reactions reporting and signal detection:** Expedited reporting of all pregnancies and abnormal pregnancy test results. Pregnancy specific questionnaires for collection of detailed initial and follow up information for pregnancies. Follow-up of abnormal pregnancy test results Follow-up of all pregnancies until outcome is known. Follow-up of infant until one year after delivery.

Safety concern	Risk minimisation measures	Pharmacovigilance activities
	forms, and information on where to find latest SmPC. 2. Therapy management a. Criteria for determining women of childbearing potential, contraceptive measures and pregnancy testing for women of childbearing potential. b. Advice in SmPC and educational materials. 3. System to ensure appropriate measures have been completed. a. Patient Card to document childbearing status, counselling and pregnancy testing.	Root cause analysis of failed PPP as part of standard follow-up. **Additional pharmacovigilance activities:** Monitoring of pregnancy prevention programme (PPP) implementation and compliance on a country basis in agreement with the relevant NCA (ie, monitoring of Patient Card completion).
Severe infection due to neutropenia and pancytopenia	**Routine risk minimisation measures:** SmPC section 4,2, 4.4 and 4.8. PL section 2 and 4. Legal status. **Additional risk minimisation measures:** None	**Routine pharmacovigilance activities beyond adverse reactions reporting and signal detection:** If there is a change in nature or frequency observed or significant clinical findings emerge, these events will be analysed in the PSURs. Event specific questionnaire for the collection of the AE and follow-up. **Additional pharmacovigilance activities:** None.
Thrombocytopenia and bleeding	**Routine risk minimisation measures:** SmPC section 4.2, 4.4 and 4.8. PL sections 2 and 4. Legal status. **Additional risk minimisation measures:** Educational HCP brochure Educational brochure for patients	**Routine pharmacovigilance activities beyond adverse reactions reporting and signal detection:** If there is a change in nature or frequency observed or significant clinical findings emerge, these events will be analysed in the PSURs. Event specific questionnaire for the collection of the AE and follow-up. **Additional pharmacovigilance activities:** None.
Cardiac failure	**Routine risk minimisation measures:** SmPC section 4.4 and 4.8. PL sections 2 and 4. Legal status.	**Routine pharmacovigilance activities beyond adverse reactions reporting and signal detection:**

Safety concern	Risk minimisation measures	Pharmacovigilance activities
	Additional risk minimisation measures: Educational HCP brochure	If there is a change in nature or frequency observed or significant clinical findings emerge, these events will be analysed in the PSURs. Event specific questionnaire for the collection of the AE and follow-up. **Additional pharmacovigilance activities:** None.
Non-melanoma skin cancer	**Routine risk minimisation measures:** SmPC section 4.4 and 4.8. PL section 2 and 4. Legal status. **Additional risk minimisation measures:** None	**Routine pharmacovigilance activities beyond adverse reactions reporting and signal detection:** If there is a change in nature or frequency observed or significant clinical findings emerge, these events will be analysed in the PSURs. Event specific questionnaire for the collection of the AE and follow-up. **Additional pharmacovigilance activities:** None.
IMPORTANT POTENTIAL RISKS		
Other second primary malignancies	**Routine risk minimisation measures:** SmPC section 4.4 and 5.3. PL section 2. **Additional risk minimisation measures:** None.	**Routine pharmacovigilance activities beyond adverse reactions reporting and signal detection:** If there is a change in nature or frequency observed or significant clinical findings emerge, these events will be analysed in the PSURs. Event specific questionnaire for the collection of the AE and follow-up. **Additional pharmacovigilance activities:** None.
Cardiac arrhythmias	**Routine risk minimisation measures:** SmPC section 4.8. PL section 4. Legal status. **Additional risk minimisation measures:** None.	**Routine pharmacovigilance activities beyond adverse reactions reporting and signal detection:** If there is a change in nature or frequency observed or significant clinical findings emerge, these events will be analysed in the PSURs. Event specific questionnaire for the collection of the AE and follow-up. **Additional pharmacovigilance activities:** None.
MISSING INFORMATION		
None		

Part VI: Summary of the Risk Management Plan

Summary of Risk Management Plan for POMALIDOMIDE TEVA 1 mg, 2 mg, 3 mg and 4 mg hard capsules

This is a summary of the risk management plan (RMP) for POMALIDOMIDE TEVA. The RMP details important risks of Pomalidomide, how these risks can be minimised, and how more information will be obtained about Pomalidomide's risks and uncertainties (missing information).

Pomalidomide's summary of product characteristics (SmPC) and its package leaflet give essential information to healthcare professionals and patients on how Pomalidomide should be used.

This summary of the RMP for Pomalidomide should be read in the context of all this information including the assessment report of the evaluation and its plain-language summary, all which is part of the European Public Assessment Report (EPAR).

Important new concerns or changes to the current ones will be included in updates of Pomalidomide's RMP.

I. The Medicine and What It is used for

Pomalidomide Teva is indicated:

- in combination with bortezomib and dexamethasone for the treatment of adult patients with multiple myeloma who have received at least one prior treatment regimen including lenalidomide.
- in combination with dexamethasone for the treatment of adult patients with relapsed and refractory multiple myeloma who have received at least two prior treatment regimens, including both lenalidomide and bortezomib, and have demonstrated disease progression on the last therapy (see SmPC for the full indication).

It contains Pomalidomide as the active substance and it is given orally.

This summary of the RMP for Pomalidomide Teva should be read in the context of all this information including the assessment report of the evaluation and its plain-language summary, all which is part of the European Public Assessment Report (EPAR).

II. Risks Associated with the Medicine and Activities to Minimise or Further Characterise the Risks

Important risks of Pomalidomide Teva, together with measures to minimise such risks and the proposed studies for learning more about Pomalidomide Teva’s risks, if any, are outlined below.

Measures to minimise the risks identified for medicinal products can be:

- Specific information, such as warnings, precautions, and advice on correct use, in the package leaflet and SmPC addressed to patients and healthcare professionals;
- Important advice on the medicine’s packaging;

- The authorised pack size — the amount of medicine in a pack is chosen so to ensure that the medicine is used correctly;
- The medicine's legal status — the way a medicine is supplied to the patient (e.g. with or without prescription) can help to minimise its risks.

Together, these measures constitute *routine risk minimisation* measures.

In the case of Pomalidomide Teva, these measures are supplemented with *additional risk minimisation measures* mentioned under relevant important risks, below.

In addition to these measures, information about adverse reactions is collected continuously and regularly analysed, so that immediate action can be taken as necessary. These measures constitute *routine pharmacovigilance activities*.

II.A List of Important Risks and Missing Information

Important risks of Pomalidomide Teva are risks that need special risk management activities to further investigate or minimise the risk, so that the medicinal product can be safely taken. Important risks can be regarded as identified or potential. Identified risks are concerns for which there is sufficient proof of a link with the use of Pomalidomide Teva. Potential risks are concerns for which an association with the use of this medicine is possible based on available data, but this association has not been established yet and needs further evaluation. Missing information refers to information on the safety of the medicinal product that is currently missing and needs to be collected.

List of important risks and missing information	
Important identified risks	• Teratogenicity • Severe infection due to neutropenia and pancytopenia • Thrombocytopenia and bleeding • Cardiac failure • Non-melanoma skin cancer
Important potential risks	• Other second primary malignancies • Cardiac arrhythmia
Missing information	• None

II.B Summary of Important Risks

[a]Important identified risk: Teratogenicity	
Evidence for linking the risk to the medicine	Pomalidomide is structurally related to thalidomide, a known human teratogen that causes severe life-threatening birth defects. Pomalidomide was found to be teratogenic in both rats and rabbits when administered during the period of major organogenesis. If pomalidomide is taken during pregnancy, a teratogenic effect of pomalidomide in humans is expected.

	Although women of childbearing potential taking pomalidomide are particularly at risk, female partners of male patients taking pomalidomide are also at risk as pomalidomide may be present in semen.
Risk factors and risk groups	The 'at risk' group comprises female patients of childbearing potential or female partners of male patients treated with pomalidomide.
Risk minimisation measures	Routine risk minimisation measures: SmPC sections 4.3, 4.4, 4.6, 4.8 and 5.3. PL section 2. Legal status. Additional risk minimisation measures: Pregnancy Prevention Programme: 1. Educational Programme consisting of: a. The Educational Healthcare Professional's Kit to include educational healthcare professional brochure, educational brochures for patients, patient card, risk awareness forms, and information on where to find latest SmPC. 2. Therapy management a. Criteria for determining women of childbearing potential, contraceptive measures and pregnancy testing for women of childbearing potential. b. Advice in SmPC and educational materials. 3. Controlled access system to ensure appropriate measures have been completed. a. Patient Card to document childbearing status, counselling and pregnancy testing.
Additional pharmacovigilance activities	Additional pharmacovigilance activities: Monitoring of pregnancy prevention programme (PPP) implementation and compliance on a country basis in agreement with the relevant NCA (ie, monitoring of Patient Card completion).
Important identified risk: Severe infection due to neutropenia and pancytopenia	
Evidence for linking the risk to the medicine	In non-clinical studies, decreased WBC counts (neutrophils, lymphocytes, and monocytes) were observed. In the clinical studies, infection was the most common non-haematological toxicity reported in patients who received pomalidomide, and approximately half of the events were Grade 3 or 4. The most commonly reported adverse reactions in clinical studies have been blood and lymphatic system disorders including neutropenia, and it is one of the major dose-limiting toxicities of pomalidomide. Pancytopenia has been identified from post-marketing data. In clinical studies, pancytopenia has been reported as a common ADR of pomalidomide treatment.
Risk factors and risk groups	Neutropenia By far the most common cause of neutropenia in oncology practice is the myelosuppressive effects of cytotoxic chemotherapy and radiation treatment. Because of their relatively short life spans, neutrophils are particularly sensitive to the effects of recently administered chemotherapy, and nadirs of neutrophil counts are frequently

	observed 7 to 10 days following the administration of chemotherapy. Less commonly, antibodies to neutrophils, bone marrow infiltration with disruption of normal marrow stromal function, and splenic sequestration can play a role. Although there are several glycoproteins with effects on neutrophil precursor cells including interleukin 3, granulocyte macrophage colony stimulating factor, and macrophage colony stimulating factor, G CSF seems to be the primary regulator of basal and emergency neutrophil production as well as mature neutrophil function. There are also negative regulatory factors of neutrophil production that are less well understood, including neutrophil elastase and the src family kinases. Neutropenia can also result from decreased neutrophil survival associated with immune destruction, sequestration, consumption at sites of infection, and the effects of inflammatory cytokines such as tumour necrosis factor. <u>Pancytopenia</u> The underlying aetiology and presentation for pancytopenia can include aplastic anaemia, megaloblastic anaemia, MDS, acute lymphoblastic leukaemia, hypersplenism, NHL, MM, acute myeloblastic leukaemia and chronic myelocytic leukaemia. Graft versus host disease has also been described within the literature as contributory to the onset of pancytopenia. A comprehensive review of 61 articles and 87 patients with pancytopenia onset after liver transplantation noted the most frequent presenting symptoms prior to the diagnosis of GvHD included rash (94.2%), fever (66.6%), diarrhoea (54%), and pancytopenia (54%). Diabetes mellitus type II may also contribute to the onset of pancytopenia. Several cross-sectional studies and case reports have documented that an increased frequency of vitamin B12 deficiency among patients with diabetes mellitus type II is commonly related to inadequate dietary intake or malabsorption. Metformin use has been unequivocally demonstrated as the prime factor associated with vitamin B12 deficiency among patients with diabetes mellitus type II. Studies assessing type 2 diabetic patients on metformin have reported the prevalence of vitamin B12 deficiency to range from 5.8% to 33%. Patients enrolled in this study were those who were on high dose (> 2 g/day) and long-term (4 years) metformin treatment, both clinical factors known to be associated with vitamin B12 deficiency. In the absence of concurrent comorbidity like renal and hepatic dysfunction, recent guidelines advocate for the use of metformin as the first-line glucose lowering agent concurrently with life-style modification approaches. Despite its superior glycaemic lowering effect, metformin has long been shown to decrease vitamin B12 levels compounding the risk of megaloblastic anaemia. The risk of developing metformin-associated vitamin B12 deficiency is greatly influenced by increasing age, metformin dose and duration of use. Severe hepatocellular disease has also demonstrated a relative relationship to anaemia and pancytopenia. This may include acute or chronic gastrointestinal haemorrhage, and hypersplenism secondary to portal hypertension. Severe hepatocellular disease predisposes to haemorrhage because of impaired blood coagulation caused by deficiency of blood coagulation factors synthesised by hepatocytes. Aplastic anaemia, which is characterised by pancytopenia and hypocellular bone marrow may follow the development of hepatitis. In patients with chronic liver disease, anaemia may be exacerbated by deficiency of folic acid and/or vitamin B12. Without regard to underlying comorbidity, drug-induced pancytopenia is acknowledged with many drug classes. Many patients are on multiple concurrent therapies that may compound the risk of myelosuppressive effects and the induction of pancytopenia. These products, which may be used alone or in combination, include radiotherapy, busulfan, melphalan, cyclophosphamide, anthracyclines, nitrosoureas,

	amiodarone, chloramphenicol, sulfonamides, gold, anti-inflammatory, anti-thyroid, psychotropic, anticonvulsant and antidepressant drugs. Infection Numerous disease-related and chemotherapy-induced factors render the subject with cancer at increased risk for infection. These include the type of cancer, depth and duration of neutropenia, and impairments in cellular function caused by cytotoxic or immunosuppressive drugs; breaches in the integument from surgical procedures, presence of indwelling plastic venous catheters, or mucositis of the gastrointestinal tract secondary to chemotherapy; and comorbid conditions such as malnutrition, deconditioning, or medical problems such as chronic obstructive lung disease or diabetes. In addition, steroid therapy induces a broad immunosuppressive effect, including impaired chemotaxis and killing by neutrophils, impaired T-cell function, and alterations in skin and mucosal barriers. Long-term or high-dose steroid therapy is a significant risk factor for invasive fungal infections in particular; such therapy also may predispose affected subjects to development of bacterial infections and Mycobacterium tuberculosis reactivation. One US study that utilised the SEER-Medicare database reported that elderly cancer patients run a 1.2 to 2.4 times higher risk of developing VZV than those without cancer. Additional noted risk factors for developing VZV included age, gender, race, immunosuppressive conditions, and certain cancer therapies (eg, haematologic cancer patients: autologous and allogeneic stem cell transplants; solid cancer patients: radiotherapy). Haematologic or solid cancer patients with immunocompromising conditions ran a higher risk of developing VZV, as did haematologic cancer patients who received stem cell transplants (despite the routine use of prophylaxis post-transplant). Cancer patients aged 75 to 85 years old had a higher risk of developing VZV than patients 85 years and older which may be attributed to the different treatment approaches (ie, more aggressive chemotherapies used in younger patients, inducing greater immune suppression) and may lead to different VZV risks. For patients with haematologic malignancies, the risk of developing shingles increases from 13% to 55% the year after a SCT. Risk factors for HBV reactivation include baseline HBV DNA > 105 copies/mL, baseline ALT levels, hepatitis B e antigen seropositivity, corticosteroid therapy, anthracyclines, rituximab, male sex, younger age, and underlying disease of lymphoma or breast cancer. The most common causes of HBV reactivation are the immunosuppression regimens adopted in solid organ transplantation, chemotherapy for onco-haematological diseases and immunosuppressive drugs used in the treatment of autoimmune diseases. The immunosuppressive properties related to chemotherapy can cause flares of HBV in people who carry HBsAg in their serum. Flares can occur despite normal baseline serum ALT levels and can lead to HBV-related morbidity and mortality. The rate of HBV reactivation after allogeneic BMT ranges 14% to 50%, with a lesser rate in autologous BMT; risk factors include corticosteroid use, donor HBsAg antibody sero-negativity, and GvHD. The time-to-recovery of cellular immunity after peripheral blood stem cell transplantation is 3 to 5 months, which is the time course during which HBV reactivation has been documented.
Risk minimisation measures	Routine risk minimisation measures: SmPC section 4.2, 4.4 and 4.8. PL section 2 and 4. Legal status. Additional risk minimisation measures: None

Important identified risk: Thrombocytopenia and bleeding	
Evidence for linking the risk to the medicine	Decreased platelets in the blood and bleeding occur due to MM so may occur during treatment with pomalidomide in combination with dexamethasone. In addition, pomalidomide may cause reductions in platelet numbers which make patients more prone to bleeding.
Risk factors and risk groups	The rate of blood cell production is both tightly regulated and highly variable. Under conditions of either increased destruction of cells, such as bleeding, haemolysis, or immune destruction of platelets, production rates of appropriate cells increase several fold. The regulation of this dynamic system is complex but for practical purposes can be conceived of as involving an interaction between a pool of pluripotent haematopoietic stem cells, capable of both infinite self-renewal and differentiation into mature blood cells and regulatory factors, including both a well-characterised set of glycoprotein haematopoietic growth factors and a less well-understood group of inhibitory factors. The primary regulator of the platelet count in humans is thrombopoietin, a glycoprotein that is produced primarily in the liver and cleared primarily by platelets and their precursors. Thrombopoietin induces growth and development of megakaryocytes; levels fluctuate with changes in platelet count due to variations in clearance. Thrombocytopenia that is encountered in oncology practice may be due to the effects of chemotherapy, or after multiple cycles of treatment, liver disease with decreased thrombopoietin levels, immune destruction, particularly in subjects with lymphoid malignancies or infection with HIV, and sequestration. The incidence of gastrointestinal haemorrhage increases with advanced age. Individuals aged 60 years and older account for 35% to 45% of all cases of UGIB. A review of epidemiology studies of the complications of peptic ulcer disease reported annual incidence rates of haemorrhage ranging from 0.19 to 0.57 per 1000 persons in the general population and an annual incidence of 0.79 per 1000 persons older than 60 years of age. A prospective study of patients undergoing upper gastrointestinal endoscopy at the National University Hospital of Iceland reported annual incidence rates of acute UGIB by age group as follows: 0.30 per 1000 individuals aged 18 to 24 years, 0.15 per 1000 individuals aged 25 to 39 years, 0.48 per 1000 individuals aged 40 to 59 years, 2.13 per 1000 individuals aged 60 to 79 years, and 5.70 per 1000 individuals aged 80 and older. Relatively common medications in the elderly that may predispose individuals to gastrointestinal haemorrhage include aspirin and NSAIDs. A meta-analysis of 24 randomised controlled trials (almost 66,000 participants) revealed gastrointestinal haemorrhage in 2.47% of patients taking aspirin compared with 1.42% taking placebo. A medical record review conducted in Japan reported incidence rates for UGIB of 2.65 and 1.29 per 1000 users of low-dose aspirin and NSAIDs, respectively. A study using the UK GPRD reported a RR of 4.1 (95% CI: 3.5-4.7) of UGIB associated with current NSAID use. Given previously published incidence rates of hospitalisation for peptic ulcer disease among nonusers of NSAIDs of 1 per 1000 person-years, Hernández-Díaz reported that this risk translates to more than 3 additional cases per 1000 exposed persons per year. Also in the UK GPRD study, the risk of serious UGIB or perforation among current users of systemic steroids (85% of which was prednisolone) was RR = 1.8. The risk was greater (RR = 2.9) among users with steroid doses ≥ 30 mg prednisone, but the test for dose-response was non-significant. Steroids were similarly associated with bleeding (OR = 1.8; 95% CI: 1.3-2.4) and perforations (OR = 1.6; 95% CI: 0.9-3.1). Simultaneous use of steroids with low-medium and high NSAID doses, respectively, produced ORs of 4.0 (95% CI: 1.3-12.0) and 12.7 (95% CI: 6.2-26.1), compared with users of none.
Risk minimisation measures	Routine risk minimisation measures:

	SmPC section 4.2, 4.4 and 4.8. PL sections 2 and 4. Legal status. Additional risk minimisation measures: HCP additional educational materials Patient brochure
Important identified risk: Cardiac failure	
Evidence for linking the risk to the medicine	Cardiac failure has been identified from post-marketing data. In clinical studies, cardiac failure has been reported as a common ADR of pomalidomide treatment.
Risk factors and risk groups	Cardiac symptoms in patients with MM can often be due to anaemia and may be due to iron overload and side effects of therapy and possible fluid overload. General risk factors for CHF include increasing age, previous heart disease, diabetes, hypertension, amyloidosis, and previous anthracycline based chemotherapy treatment. Cardiotoxicity of anthracyclines (eg, doxorubicin, daunorubicin and epirubicin) is usually cumulative and dose dependent. Risk factors include older age, pre-existing heart disease and hypertension.
Risk minimisation measures	Routine risk minimisation measures: SmPC section 4.4 and 4.8. PL sections 2 and 4. Legal status. Additional risk minimisation measures: HCP additional educational materials
Important identified risk: Non-melanoma skin cancer	
Evidence for linking the risk to the medicine	Patients treated with pomalidomide may be at an increased risk of developing new cancers (including skin cancers). In clinical studies, NMSC has been reported in patients receiving pomalidomide. Drug reaction with eosinophilia and systemic symptoms, toxic epidermal necrolysis and Stevens-Johnson syndrome have been observed in the post-marketing setting.
Risk factors and risk groups	Skin colour and being exposed to sunlight are recognised risk factors for NMSC. NMSC is the most frequent malignancy mainly in fair-skinned populations. However other risk factors such as immune disorders, tobacco use, photosensitive drugs, and viral infections (human papilloma virus, HIV) have been reported to be associated with NMSC in rare instances. Rates of NMSC are higher in men as compared to women. NMSC rates are also higher in older age groups. One study based on the US insured population reported the mean age of NMSC was 69 years.
Risk minimisation measures	Routine risk minimisation measures: SmPC section 4.4 and 4.8. PL section 2 and 4. Legal status. Additional risk minimisation measures: None
Important potential risk: Other second primary malignancies	
Evidence for linking the risk to the medicine	Patients treated with pomalidomide may be at an increased risk of developing new cancers. In clinical studies, SPM has been reported in patients receiving pomalidomide.

Risk factors and risk groups	Travis has grouped second primary cancers into three major groups based on the predominant etiologic factors ie, treatment related, syndromic, and those due to shared etiologic factors, while emphasising the non-exclusivity of these groups. In the following, possible explanations for the epidemiologic findings presented in the previous section will be discussed. **Prolonged survival as a result of improved therapies** Due to improvements in the care of patients with cancer, the number of cancer survivors has been increasing in recent years. Increased longevity increases the risk of developing a second malignancy, whether due to the late sequelae of treatment, lifestyle factors, environmental exposures, or host factors (eg, aging, genetic factors, gene-environment interactions), or a combination of these factors. Second solid tumours are a leading cause of mortality among several populations of long-term survivors. As reported from the SEER Cancer Statistics Review 1975 to 2009, the 5-year relative survival among MM patients has increased from 25.1% among patients first diagnosed in 1975 to 1977 to 42.6% among patients first diagnosed between 2002 and 2008 ($p < 0.05$). Among patients aged less than 65 years at first diagnosis between 2002 and 2008, 5-year relative survival is 54.4%; among those aged 65 years and older, survivorship is 31.3%. **Heredity** Additional insight has also been obtained in elucidating the risk of malignancies in close family members of patients affected by MM. The available data show an increased risk of more than one malignancy in MM patients and first-degree relatives compared to the general population. The reason for this finding is still unclear but may clearly involve risk conferred by shared genetic factors.
Risk minimisation measures	Routine risk minimisation measures: SmPC section 4.4 and 5.3. PL section 2. Legal status. Additional risk minimisation measures: None
Important potential risk: Cardiac arrhythmias	
Evidence for linking the risk to the medicine	Patients treated with pomalidomide in combination with dexamethasone may be at increased risk of cardiac arrhythmias. It is unclear whether pomalidomide can cause cardiac arrhythmias. In clinical studies, a greater proportion of patients treated with pomalidomide in combination with dexamethasone reported cardiac arrhythmias compared to patients who were treated with high dose dexamethasone.
Risk factors and risk groups	The ATRIA study showed that AF occurred more often in men than in women and the prevalence rates were 0.1% in people < 55 years of age to 3.8% in those ≥ 60 years of age to 9% in people ≥ 80 years of age.
Risk minimisation measures	Routine risk minimisation measures: SmPC section 4.8. PL sections 2 and 4. Legal status. Additional risk minimisation measures: None

[a] Evidence for linking the risk to the medicine and Risk factors and risk groups were aligned with originator's (Imnovid®, Bristol-Myers Squibb EEIG) RMP v18.0.

II.C Post-Authorisation Development Plan

II.C.1 Studies Which Are Conditions of the Marketing Authorisation

There are no studies which are conditions of the marketing authorisation or specific obligation of Pomalidomide Teva.

II.C.2 Other Studies in Post-Authorisation Development Plan

Activity and status	Summary of objectives	Safety concerns addressed	Milestones	Due dates
Category 3 – Required additional pharmacovigilance activities				
Monitoring of pregnancy prevention programme (PPP) Ongoing	Monitoring of implementation of PPP	Teratogenicity	Routine PSURs in line with DLP of the latest EURD-List.	Data will be reviewed on an ongoing basis as part of signal detection and reported within PSURs in line with EURD-List.

Part VII: ANNEXES

Table of contents

Annex 4 – Specific Adverse Drug Reaction Follow-Up Forms

Follow-up forms

Important Identified or Potential Risk	Follow-up Form Title
Teratogenicity	Event-Specific Questionnaire for HCP - Pregnancy Background (Patient or Partner of Patient) Event-Specific Questionnaire for HCP - Pregnancy Follow-up (Patient or Partner of Patient) Event-Specific Questionnaire for HCP - Pregnancy Outcome (Patient or Partner of Patient) Event-Specific Questionnaire for Primary Care Physician or Pediatrician - Infant Follow-up
Severe Infection due to Neutropenia and Pancytopenia	Neutropenia
Thrombocytopenia and Bleeding	Thrombocytopenia/Bleeding
Cardiac Failure	Cardiac Failure
Non-melanoma Skin Cancer	Second Primary Malignancies
Other Second Primary Malignancies	Second Primary Malignancies
Cardiac Arrhythmia	Cardiac Arrhythmia and ECG Changes

Pomalidomide - Event-Specific Questionnaire for HCP Pregnancy Background (Patient or Partner of Patient) v1.1

- Supplement to the (S)AE Form -

Follow-up to Case No.: .....

Date of receipt (dd/mm/yyyy): .....

PATIENT INFORMATION:

Age: .....

Gender: ☐ M ☐ F Pregnant: ☐ Y ☐ N

Height ..... cm/ ..... in Weight ..... kg/ ..... lbs

Reporter Information			
REPORTER NAME:			
ADDRESS:		CITY, STATE, ZIP, COUNTRY:	
PHONE NO.:		FAX NO.:	
Obstetrician Information (Please provide)			
OBSTETRICIAN NAME:			
ADDRESS:		CITY, STATE, ZIP, COUNTRY:	
PHONE NO.:		FAX NO.:	
Patient Information			
Patient ID:	Date Of Birth:	ETHNICITY: ☐ WHITE ☐ AFRICAN-AMERICAN ☐ ASIAN ☐ OTHER, SPECIFY:	
Partner of Patient Information ☐ Not applicable			
DATE OF BIRTH	ETHNICITY: ☐ WHITE ☐ AFRICAN-AMERICAN ☐ ASIAN ☐ OTHER, SPECIFY:		
Patient Treatment Information: pomalidomide (Brand name)			
LOT NO.:	EXPIRY DATE:	DOSE:	FREQUENCY:
ROUTE:	START DATE:	STOP DATE:	
INDICATION FOR USE:			

CYTOGENETIC ABNORMALITIES: ☐ NO ☐ YES If Yes, specify**:**

Current Pregnancy			
Date of Last Menstrual Period:		Estimated Delivery Date:	
PREGNANCY TEST	DATE	REFERENCE RANGE	RESULT
Urine qualitative			
Serum quantitative			
Prenatal Tests			
	DATE	RESULT	
Ultrasound			
Ultrasound			
Ultrasound			
Amniocentesis			
Maternal serum AFP			
Pregnancy History			
No. of previous pregnancies: Date of last pregnancy:	No. of full term deliveries:	No. of pre-term births:	
No. of fetal deaths:	No. of living children:	No. of abortions: Elective ..... Spontaneous	
Type of delivery: ☐ Vaginal ☐ C-section			
Did birth defect occur in any previous pregnancy? ☐ No ☐ Yes ☐ Unknown If Yes, specify:			
Did a stillbirth or miscarriage occur in any previous pregnancy? ☐ No ☐ Yes ☐ Unknown 1) If Yes, in what week of pregnancy did the stillbirth or miscarriage occur? ..... week 2) Was there any birth defect noted? ☐ No ☐ Yes, specify:			
Relevant Medical History			
☐ No ☐ Yes If Yes, specify**:**			

MEDICAL HISTORY	DATE OF DIAGNOSIS	MEDICAL HISTORY	DATE OF DIAGNOSIS

Social History	
ALCOHOL ☐ NO ☐ YES IF YES, SPECIFY AMOUNT/UNIT CONSUMED PER DAY**:**	
TOBACCO ☐ NO ☐ YES	IV OR RECREATIONAL DRUG USE ☐ NO ☐ YES, SPECIFY

Family History: CONGENITAL ABNORMALITIES ☐ NO ☐ YES, SPECIFY .....

If there is a family history of congenital abnormalities, was there a consultation with a Geneticist? ☐ NO ☐ YES, SPECIFY

Environmental Exposure (e.g. RADIATION, CHEMICAL EXPOSURE) ☐ NO ☐ YES, SPECIFY :

Medications/Treatments (including herbal, alternative and over-the-counter medicines and dietary supplements) During Pregnancy

MEDICATION/TREATMENT	START DATE	STOPDATE/ ONGOING	INDICATION

Adverse Event(s) During Pregnancy

EVENT(S)	SERIOUS		SERIOUS CRITERIA[1]	START DATE	STOP DATE/ ONGOING	CAUSAL RELATIONSHIP TO POMALIDOMIDE		
	NO	YES				YES	NO	IF NO, WHAT MEDICATIONS, DISEASE STATES, etc, PLAYED A ROLE IN THE EVENT?

Serious Criteria: 1) death, 2) life-threatening, 3) required inpatient hospitalization or prolongation of existing hospitalization, 4) a persistent or significant disability/incapacity, 5) a congenital anomaly/birth defect, 6) medically significant

Root cause of pregnancy

1. What forms of birth control was your patient using while on pomalidomide before becoming pregnant or impregnating their partner? Please check all that apply.
☐ Tubal ligation
☐ IUD
☐ Hormonal birth control

☐ Partner's vasectomy
☐ Male latex or synthetic condom
☐ Diaphragm
☐ Cervical cap or shield
☐ Spermicide or sponge
☐ Withdrawal
☐ Abstinence
2. Was your patient or their partner at any time during use of pomalidomide without contraception for even one day? ☐ No, please proceed to Question 5 ☐ Yes, please answer Question 3, Question 4, Question 5, and Question 6
3. If applicable per Question 2, how often did your patient have unprotected sexual intercourse? ☐ Multiple times ☐ Once a week ☐ Once every 2 weeks ☐ Once a month ☐ Not at all ☐ Other, specify .....
4. If applicable per Question 2, why did your patient and/or their partner interrupt or stop using contraception? ☐ Wanted a child ☐ Partner disapproved ☐ Side effects ☐ Health concerns ☐ Inconvenient to use ☐ Other, specify
5. Please ask your patient if they received the pomalidomide Patient Information (e.g. Medication Guide or patient leaflet). ☐ No, please proceed to Question 5.3 ☐ Yes, please answer the following question
5.1 Please ask your patient if they read pomalidomide Patient Information (e.g. Medication Guide or patient leaflet). ☐ No, please proceed to Question 5.3 ☐ Yes, please answer the following question
5.2 Please ask your patient if they understood the information in the pomalidomide Patient Information (e.g. Medication Guide or patient leaflet). ☐ No ☐ Yes
5.3 Please ask your patient where most of their knowledge about contraception during pomalidomide use came from. ☐ Physician who prescribed pomalidomide

☐ Pomalidomide Medication Guide ☐ Other, specify: .....
6. Please ask your patient if they felt they had a good understanding of the risk of pregnancy during pomalidomide use. ☐ Yes ☐ No ☐ Don't know

REPORTER INFORMATION:

☐ Physician; ☐ Patient; ☐ Other, please specify .....

.....

Name and title: .....

.....

Affiliation: .....

.....

Address: .....

.....

Phone number: ..... E-mail: .....

.....

Date of report (dd/mm/yy): .....

Signature: .....

Pomalidomide - Event-Specific Questionnaire for HCP Pregnancy Follow-up (Patient or Partner of Patient) v1.1

- Supplement to the (S)AE Form -

Follow-up to Case No.: .....

Date of receipt (dd/mm/yyyy): .....

PATIENT INFORMATION:

Age: .....

Gender: ☐ M ☐ F Pregnant: ☐ Y ☐ N

Height ..... cm/ ..... in Weight ..... kg/ ..... lbs

Date:	**Period Covered**: ..... to ..... Date Date	
Reporter Information		
REPORTER NAME:		
ADDRESS:	CITY, STATE, ZIP. COUNTRY:	
PHONE NO.:	FAX NO.:	
Name of Patient or Pregnant Partner of Male Patient:		
Current Pregnancy		
Prenatal Tests (If any additional medical records relating to these prenatal tests are available, please attach along with this form)		
Test	DATE	RESULT
Ultrasound		
Ultrasound		
Ultrasound		
Amniocentesis		
Maternal Serum AFP		
Other Tests, Specify:		
Pregnancy Type ☐ SINGLETON ☐ TWIN ☐ TRIPLET ☐ OTHER, SPECIFY:		
Medications/treatments (including herbal, alternative and over-the-counter medicines and dietary supplements) During Pregnancy		

Medication/Treatment	START DATE	STOP DATE/ CONTINUING	INDICATION

Adverse Event(s) During Pregnancy

EVENT(S)	SERIOUS		SERIOUS CRITERIA[1]	ONSET DATE	STOP DATE/ ONGOING	CAUSAL RELATIONSHIP TO POMALIDOMIDE		
	No	YES				YES	No	IF NO, WHAT MEDICATIONS, DISEASE STATES, etc, PLAYED A ROLE IN THE EVENT?

Criteria: 1) death, 2) life-threatening, 3) required inpatient hospitalization or prolongation of existing hospitalization, 4) a persistent or significant disability/incapacity, 5) a congenital anomaly/birth defect, 6) medically significant

REPORTER INFORMATION:

☐ Physician; ☐ Patient; ☐ Other, please specify.....

.....

Name and title:.....

.....

Affiliation:.....

.....

Address:.....

.....

Phone number:..... E-mail:.....

.....

Date of report (dd/mm/yy):.....

Signature: .....

Pomalidomide - Event-Specific Questionnaire for HCP Pregnancy Outcome (Patient or Partner of Patient) v1.1

- Supplement to the (S)AE Form -

Follow-up to Case No.:.....

Date of receipt (dd/mm/yyyy):.....

PATIENT INFORMATION:

Age:.....

Gender: ☐ M ☐ F Pregnant: ☐ Y ☐ N

Height ..... cm/ ..... in Weight ..... kg/ ..... lbs

Reporter Information			
REPORTER NAME:			
ADDRESS:			CITY, STATE, ZIP, COUNTRY:
PHONE NO.:			FAX NO.:
Patient Information			
Patient ID:	Date Of Birth:		ETHNICITY: ☐ WHITE ☐ AFRICAN-AMERICAN ☐ ASIAN ☐ OTHER, SPECIFY:
Partner of Patient Information ☐ Not applicable			
DATE OF BIRTH:	ETHNICITY: ☐ WHITE ☐ AFRICAN-AMERICAN ☐ ASIAN ☐ OTHER, SPECIFY:		
Pregnancy Type	☐ SINGLETON ☐ TWIN ☐ TRIPLET ☐ OTHER, SPECIFY:		
Pregnancy Outcome			
DATE OF DELIVERY:			GESTATION AGE AT DELIVERY:
DELIVERY DETAILS	NO	YES	ADDITIONAL COMMENTS
Normal	☐	☐	
C-section	☐	☐	
Induced	☐	☐	
Assisted (e.g., forceps)	☐	☐	
Elective termination	☐	☐	Date:
Spontaneous abortion (≤ 20	☐	☐	Weeks from LMP:

weeks)			
Fetal death/Stillbirth(> 20 weeks)	☐	☐	
Were the products of conception examined?	☐	☐	If yes, was the fetus normal? ☐ Yes ☐ No ☐ Unknown If no, describe: _____
Obstetrics Information			
	NO	YES	
Complications During Pregnancy	☐	☐	If Yes, specify: _____
Complications During Labor/Delivery	☐	☐	If Yes, specify: _____
Post-partum Maternal Complications	☐	☐	If Yes, specify: _____
Fetal and Neonatal Status			
	NO	YES	
Live Normal Infant	☐	☐	
Fetal Distress	☐	☐	If Yes, please specify:
Intra-uterine Growth Retardation	☐	☐	If Yes, please specify:
Neonatal Complications ***PLEASE PROVIDE A BRIEF SUMMARY OF THE MANAGEMENT OF THE COMPLICATIONS.**	☐	☐	If Yes, please specify: _____
Birth Defect Noted?	☐	☐	If Yes, please specify: _____
Sex: ☐Male ☐Female **Birth Weight:** .....lbs .....oz ***or*** .....kg **Length:** .....inches ***or*** .....cm			
Apgar Score:	Unknown:	1 min:	5 min: 10 min:

REPORTER INFORMATION:

☐ Physician; ☐ Patient; ☐ Other, please specify .....

.....

Name and title: .....

.....

Affiliation: .....

.....

Address: .....

.....

Phone number: ..... E-mail: .....

.....

Date of report (dd/mm/yy): .....

Signature: .....

Pomalidomide - Event-Specific Questionnaire for Primary Care Physician or Pediatrician - Infant Follow-up v1.1

- Supplement to the (S)AE Form -

Follow-up to Case No.: .....

Date of receipt (dd/mm/yyyy): .....

PATIENT INFORMATION:

Age: .....

Gender: ☐ M ☐ F Pregnant: ☐ Y ☐ N

Height ..... cm/ ..... in Weight ..... kg/ ..... lbs

Date of Assessment: .....
Age in Months:
Weight (at the time of this assessment): lbs oz or kg
Length (at the time of this assessment): inches or cm
Name of Patient on pomalidomide:
Name of Infant (if known)
Please provide information for the period [Date] to [Date]: ..... to .....

Birth Defects/Anomalies:

New birth defects or anomalies noted since previous report? ☐ Yes ☐ No

If **Yes**, please list the birth defects/anomalies below:

BIRTH DEFECT/ANOMALY	**WAS THE DEFECT/ ANOMALY ATTRIBUTED TO Pomalidomide THERAPY?** (Y/N/Unknown)	**FACTORS THAT MAY HAVE CONTRIBUTED TO THIS OUTCOME:** (e.g. family history, maternal age, obesity, alcohol consumption during pregnancy, etc.)	**DEFECT/ ANOMALY NOTED PRIOR TO BIRTH?** (Y/N)	**INFANT AGE WHEN DEFECT/ ANOMALY WAS NOTED** (specify weeks or months)

Developmental Assessment:

Is the child developing normally for his/her age? ☐ Yes ☐ No

If No, please define your concerns regarding any developmental issues or abnormalities:

.....

.....

.....

Diagnosis date of any developmental issues: .....

Infant Illnesses, Hospitalizations, Drug Therapies:

Infant Illnesses	Hospitalized?	Drug Therapies
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

REPORTER INFORMATION:

☐ Physician; ☐ Patient; ☐ Other, please specify.....

.....

Name and title:.....

.....

Affiliation:.....

.....

Address:.....

.....

Phone number:..... E-mail:.....

.....

Date of report (dd/mm/yy):.....

Signature: .....

Pomalidomide - Event -Specific Questionnaire Neutropenia v1.1

- Supplement to the (S)AE Form -

Follow-up to Case No.:.....

Date of receipt (dd/mm/yyyy):.....

PATIENT INFORMATION:

Age:.....

Gender: ☐ M ☐ F Pregnant: ☐ Y ☐ N

Height ..... cm/ ..... in Weight ..... kg/ ..... lbs

Race/Ethnicity: ☐ Aboriginal ☐ African American ☐ Asian

☐ American Indican or Alaskan Native ☐ Native Hawaiian or other Pacific Islander

☐Torres Strait Islander ☐ White ☐ Black ☐ Non Hispanic

Age Group: .....

Age Group Definition: Neonate: 0 - 27 days, Infant: 28 days to 23 months, Child: 2 years to 11years, Adolescent: 12 years to 18 years, Adult: More than 18 years and less than or equal to 65 years and Elderly: equal or greater than 66 years)

Suspect Products: Please provide suspect product(s) information [those product(s) that are suspected to be associated with one or more adverse events]:

	Suspect Product #1	Suspect Product #2	Suspect Product #3
Product name			
Daily dose and regimen			
Route of administration			
Indication			
Start date or treatment duration (DD-MMM-YYYY)			
Stop date (DD-MMM-YYYY)			
Lot/Batch number(s)			
Expiration date(s)			
Action Taken with the suspect product			

(Choose from one of the following for action Taken with Suspect Product: Drug withdrawn, Dose reduced, Dose increased, Dose not changed, Unknown)

Adverse Event (AE) Description: Please provide diagnosis or symptoms/signs if diagnosis is unavailable.

	Adverse Event #1	Adverse Event #2	Adverse Event #3	Adverse Event #4
Add Diagnosis Here →				
Start Date (DD/MMM/YYYY)				
Stop Date (DD/MMM/YYYY)				
Time lag if AE occurred after cessation of treatment with the suspect product(s):				
Required Hospitalization (Yes/No)				
Life-Threatening (Yes/No)				
Persistent or significant disability (Yes/No)				
Congenital abnormality (Yes/No)				
Cause of Death (Yes/No)				
Treatment of Adverse Event				
Outcome (recovery and sequelae, if any)				
Did the event(s) abate after suspect Product was stopped or dose reduced? (Yes/No)				
Did the event recur after reintroducing (Yes/No)				

Please summarize course of reported events including signs and symptoms in chronological order:

Diagnostic tests (use additional pages if needed)**:** Please indicate test unit where applicable.

Date	Test Name	Pre-treatment value	AE onset value	AE resolution value	Normal low	Normal high
	WBC					
	ANC					

Please provide causal relationship assessment between the suspect product(s) and adverse event(s):

Concomitant Medications (use additional pages if needed):

Did the Patient take any concomitant medication? ☐ Yes (please complete below) ☐ None ☐ Unknown

Please include any antiemetics.

Medication Name	Daily dose and regimen	Route of administration	Indication	Start date DD-MMM-YYYY	Stop date DD-MMM-YYYY

Other Etiological Factors: ☐ Yes (please complete below) ☐ None ☐ Unknown

☐Relevant medical and/or drug history (please specify), including start date or duration:

☐Family history (please specify)

☐Drug/alcohol/tobacco abuse

☐Other (please specify)

Additional questions:

What treatments were given for the neutropenia? Please include dates. Did the patient receive G-CSF? GM-CSF? Please provide details.

Did your patient experience an infection in association with the neutropenia?

☐ Yes ☐ No

If yes, please provide location of the infection.

Does the patient have a history of recurrent infection?

☐ Yes ☐ No

If yes, please explain.

Please provide the stage/classification of the patient's disease at the time of the infection.

Does your patient have a medical history of autoimmune disease, abnormal disease of spleen, bone marrow disease, etc.?

Has your patient received prior radiation therapy? If so, please provide treatment details including dates.

Does your patient have a medical history of cancer effecting bone marrow?

Please include culture / serology / bone marrow studies / x-ray results for the event of infection.

Health Practitioner Name (Print)

Health Practitioner Name (Signature)

Additional information regarding this Adverse Event Report:

Description of event: [narrative]

REPORTER INFORMATION:

☐ Physician; ☐ Patient; ☐ Other, please specify.....

Name and title:.....

Affiliation:.....

Address:.....

Phone number:..... E-mail:.....

Date of report (dd/mm/yy):.....

Signature: .....

Pomalidomide - Event-Specific Questionnaire Thrombocytopenia/Bleeding v1.1

- Supplement to the (S)AE Form -

Follow-up to Case No.: .....

Date of receipt (dd/mm/yyyy): .....

PATIENT INFORMATION:

Age: .....

Gender: ☐ M ☐ F Pregnant: ☐ Y ☐ N

Height ..... cm/ ..... in Weight ..... kg/ ..... lbs

Race/Ethnicity: ☐ Aboriginal ☐ African American ☐ Asian

☐ American Indican or Alaskan Native ☐ Native Hawaiian or other Pacific Islander

☐Torres Strait Islander ☐ White ☐ Black ☐ Non Hispanic

Age Group: .....

Age Group Definition: Neonate: 0 - 27 days, Infant: 28 days to 23 months, Child: 2 years to 11years, Adolescent: 12 years to 18 years, Adult: More than 18 years and less than or equal to 65 years and Elderly: equal or greater than 66 years)

Suspect Products: Please provide suspect product(s) information [those product(s) that are suspected to be associated with one or more adverse events]:

	Suspect Product #1	Suspect Product #2	Suspect Product #3
Product name			
Daily dose and regimen			
Route of administration			
Indication			
Start date or treatment duration (DD-MMM-YYYY)			
Stop date (DD-MMM-YYYY)			
Lot/Batch number(s)			
Expiration date(s)			
Action Taken with the suspect product			

(Choose from one of the following for action Taken with Suspect Product: Drug withdrawn, Dose reduced, Dose increased, Dose not changed, Unknown)

Adverse Event (AE) Description: Please provide diagnosis or symptoms/signs if diagnosis is unavailable.

	Adverse Event #1	Adverse Event #2	Adverse Event #3	Adverse Event #4
Add Diagnosis Here →				
Start Date (DD/MMM/YYYY)				
Stop Date (DD/MMM/YYYY)				
Time lag if AE occurred after cessation of treatment with the suspect product(s):				
Required Hospitalization (Yes/No)				
Life-Threatening (Yes/No)				
Persistent or significant disability (Yes/No)				
Congenital abnormality (Yes/No)				
Cause of Death (Yes/No)				
Treatment of Adverse Event				
Outcome (recovery and sequelae, if any)				
Did the event(s) abate after suspect Product was stopped or dose reduced? (Yes/No)				
Did the event recur after reintroducing (Yes/No)				

Please summarize course of reported events including signs and symptoms in chronological order:

Diagnostic tests (use additional pages if needed)**:** Please indicate test unit where applicable.

Date	Test Name	Pre-treatment value	AE onset value	AE resolution value	Normal low	Normal high
	Platelets					
	PT					
	aPTT					
	INR					

	ESR					
	LFTs					
	Factor VIII					
	Factor IX					

Please provide causal relationship assessment between the suspect product(s) and adverse event(s):

Concomitant Medications (use additional pages if needed):

Did the Patient take any concomitant medication? ☐ Yes [please complete below; Please provide relevant concomitant medications, including thromboprophylaxis), and possible platelet transfusion need to prevent hemorrhagic event]

☐ None ☐ Unknown

Medication Name	Daily dose and regimen	Route of administration	Indication	Start date DD-MMM-YYYY	Stop date DD-MMM-YYYY

Other Etiological Factors: ☐ Yes (please complete below) ☐ None ☐ Unknown

☐ Relevant medical and/or drug history (please specify), including start date or duration:

☐ Family history (please specify)

☐ Drug/alcohol/tobacco abuse

☐ Other (please specify)

Additional questions:

1) Please provide location of the bleeding/hemorrhage.

2) Relevant medical history: Does the patient have:

a. History of anemia? Was patient transfusion dependent? If yes, since when and how frequent?

b. Episodes of hypotension? Hypertension? Gingivorrhagia or epistaxis? Headaches? Pallor? Dyspnea? Weakness? Please describe.

c. History of bleeding/hemorrhage? Coagulation disorder? Please describe.

3) Please provide date of diagnosis of underlying disease, stage at the time of diagnosis and stage of the patient's disease at the time of the event.

4) Please include bone marrow studies / x-ray / CT scan results for the event of thrombocytopenia/ bleeding/hemorrhage.

5) What treatments were given for the thrombocytopenia/ bleeding/ hemorrhage? Please include dates/dose.

Health Practitioner Name (Print)

Health Practitioner Name (Signature)

Additional information regarding this Adverse Event Report:

Description of event: [narrative]

REPORTER INFORMATION:

☐ Physician; ☐ Patient; ☐ Other, please specify .....

Name and title: .....

Affiliation: .....

Address: .....

Phone number: ..... E-mail: .....

Date of report (dd/mm/yy): .....

Signature: .....

Pomalidomide - Event-Specific Questionnaire Cardiac Failure v1.1

- Supplement to the (S)AE Form -

Follow-up to Case No.:.....

Date of receipt (dd/mm/yyyy):.....

PATIENT INFORMATION:

Age:.....

Gender: ☐ M ☐ F Pregnant: ☐ Y ☐ N

Height ..... cm/ ..... in Weight ..... kg/ ..... lbs

Race/Ethnicity: ☐ Aboriginal ☐ African American ☐ Asian

☐ American Indican or Alaskan Native ☐ Native Hawaiian or other Pacific Islander

☐Torres Strait Islander ☐ White ☐ Black ☐ Non Hispanic

Age Group: .....

Age Group Definition: Neonate: 0 - 27 days, Infant: 28 days to 23 months, Child: 2 years to 11years, Adolescent: 12 years to 18 years, Adult: More than 18 years and less than or equal to 65 years and Elderly: equal or greater than 66 years)

Suspect Products: Please provide suspect product(s) information [those product(s) that are suspected to be associated with one or more adverse events]:

	Suspect Product #1	Suspect Product #2	Suspect Product #3
Product name			
Daily dose and regimen			
Route of administration			
Indication			
Start date or treatment duration (DD-MMM-YYYY)			
Stop date (DD-MMM-YYYY)			
Lot/Batch number(s)			
Expiration date(s)			
Action Taken with the suspect product			

(Choose from one of the following for action Taken with Suspect Product: Drug withdrawn, Dose reduced, Dose increased, Dose not changed, Unknown)

Adverse Event (AE) Description: Please provide diagnosis or symptoms/signs if diagnosis is unavailable.

	Adverse Event #1	Adverse Event #2	Adverse Event #3	Adverse Event #4
Add Diagnosis Here →				
Start Date (DD/MMM/YYYY)				
Stop Date (DD/MMM/YYYY)				
Time lag if AE occurred after cessation of treatment with the suspect product(s):				
Required Hospitalization (Yes/No)				
Life-Threatening (Yes/No)				
Persistent or significant disability (Yes/No)				
Congenital abnormality (Yes/No)				
Cause of Death (Yes/No)				
Treatment of Adverse Event				
Outcome (recovery and sequelae, if any)				
Did the event(s) abate after suspect Product was stopped or dose reduced? (Yes/No)				
Did the event recur after reintroducing (Yes/No)				

Please summarize course of reported events including signs and symptoms in chronological order:

Diagnostic tests (use additional pages if needed)**:** Please indicate test unit where applicable.

Date	Test Name	Pre-treatment value	AE onset value	AE resolution value	Normal low	Normal high
	Calcium					
	Magnesium					

	Total CPK					
	CK-MB					
	Troponins					
	BNP					
	WBC					
	RBC					
	Platelets					
	Hemoglobin					
	Hematocrit					

Please provide causal relationship assessment between the suspect product(s) and adverse event(s):

Concomitant Medications (use additional pages if needed):

Did the Patient take any concomitant medication? ☐ Yes (please complete below) ☐ None ☐ Unknown

Please include any antiemetics.

Medication Name	Daily dose and regimen	Route of administration	Indication	Start date DD-MMM-YYYY	Stop date DD-MMM-YYYY

Other Etiological Factors: ☐ Yes (please complete below) ☐ None ☐ Unknown

☐ Relevant medical and/or drug history (please specify), including start date or duration:

☐ Family history (please specify)

☐Drug/alcohol/tobacco abuse

☐Other (please specify)

Additional questions:

1) Did the cardiac failure occur prior to therapy? ☐ Yes ☐ No

a. If the cardiac failure occurred prior to therapy, would you consider it an exacerbation? ☐ Yes ☐ No

b. Please provide the date the exacerbation was diagnosed_____

2) Please circle classification of cardiac failure:

a) Class I (mild) Patients with cardiac disease but without limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea or angina pain

b) Class II (mild) Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or angina pain.

c) Class III (moderate) Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea, or angina pain.

d) Class IV (severe) Patients with cardiac disease resulting in the inability to carry on any physical activity without discomfort. Symptoms of heart failure or the angina syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

3) Please provide results for EKG, echocardiogram, angiogram, CT scan, MRI and ejection fraction.

4) Did the patient receive any recent blood transfusions or IV infusions? ☐ Yes ☐ No
If yes, please specify what was transfused and provide the amount transfused with dates.

5) Does the patient have other cardiac history including congenital heart disease, coronary artery disease, cardiac stents, myocardial infarction, valvular heart disease, cardiomyopathy, endocarditis, or myocarditis?

6) Please provide any associated risk factors including history of hyperlipidemia, obesity, hypertension, COPD, renal disease, diabetes, sepsis, substance abuse, and family history of heart disease.

7) Any exposure to other chemotherapeutic agents (previous and/or ongoing)? Please specify.

8) Are there any concurrent events that contributed or led up to the cardiac failure? Please specify.

9) What treatments/interventions were provided to the patient for the cardiac failure?

Health Practitioner Name (Print)

_____

_____

Health Practitioner Name (Signature)

Additional information regarding this Adverse Event Report:

Description of event: [narrative]

REPORTER INFORMATION:

☐ Physician; ☐ Patient; ☐ Other, please specify.....

.....

Name and title:.....

.....

Affiliation:.....

.....

Address:.....

.....

Phone number:..... E-mail:.....

.....

Date of report (dd/mm/yy):.....

Signature: .....

Pomalidomide - Event-Specific Questionnaire Second Primary Malignancies v1.1

- Supplement to the (S)AE Form -

Follow-up to Case No.:.....

Date of receipt (dd/mm/yyyy):.....

PATIENT INFORMATION:

Age:.....

Gender: ☐ M ☐ F Pregnant: ☐ Y ☐ N

Height ..... cm/ ..... in Weight ..... kg/ ..... lbs

Race/Ethnicity: ☐ Aboriginal ☐ African American ☐ Asian

☐ American Indican or Alaskan Native ☐ Native Hawaiian or other Pacific Islander

☐Torres Strait Islander ☐ White ☐ Black ☐ Non Hispanic

Age Group: .....

Age Group Definition: Neonate: 0 - 27 days, Infant: 28 days to 23 months, Child: 2 years to 11years, Adolescent: 12 years to 18 years, Adult: More than 18 years and less than or equal to 65 years and Elderly: equal or greater than 66 years)

Suspect Products: Please provide suspect product(s) information [those product(s) that are suspected to be associated with one or more adverse events]:

	Suspect Product #1	Suspect Product #2	Suspect Product #3
Product name			
Daily dose and regimen			
Route of administration			
Indication			
Start date or treatment duration (DD-MMM-YYYY)			
Stop date (DD-MMM-YYYY)			
Lot/Batch number(s)			
Expiration date(s)			
Action Taken with the suspect product			

(Choose from one of the following for action Taken with Suspect Product: Drug withdrawn, Dose reduced, Dose increased, Dose not changed, Unknown)

Adverse Event (AE) Description: Please provide diagnosis or symptoms/signs if diagnosis is unavailable.

	Adverse Event #1	Adverse Event #2	Adverse Event #3	Adverse Event #4
Add Diagnosis Here →				
Start Date (DD/MMM/YYYY)				
Stop Date (DD/MMM/YYYY)				
Time lag if AE occurred after cessation of treatment with the suspect product(s):				
Required Hospitalization (Yes/No)				
Life-Threatening (Yes/No)				
Persistent or significant disability (Yes/No)				
Congenital abnormality (Yes/No)				
Cause of Death (Yes/No)				
Treatment of Adverse Event				
Outcome (recovery and sequelae, if any)				
Did the event(s) abate after suspect Product was stopped or dose reduced? (Yes/No)				
Did the event recur after reintroducing (Yes/No)				

Please summarize course of reported events including signs and symptoms in chronological order:

Diagnostic tests (use additional pages if needed)**:** Please indicate test unit where applicable.

Date	Test Name	Pre-treatment value	AE onset value	AE resolution value	Normal low	Normal high
	Calcium					
	Phosphate					
	Uric acid					
	Creatinine					

	Potassium					
	LDH					
	Albumin					
	Protein					

Please provide causal relationship assessment between the suspect product(s) and adverse event(s):

Concomitant Medications (use additional pages if needed):

Did the Patient take any concomitant medication? ☐ Yes (please complete below) ☐ No ☐ Unknown

Please include any antiemetics.

Medication Name	Daily dose and regimen	Route of administration	Indication	Start date DD-MMM-YYYY	Stop date DD-MMM-YYYY

Other Etiological Factors: ☐ Yes (please complete below) ☐ None ☐ Unknown

☐Relevant medical and/or drug history (please specify), including start date or duration:

☐Family history (please specify)

☐Drug/alcohol/tobacco abuse

☐Other (please specify)

Additional questions:

When querying about SPMs, specify the malignancy or diagnosis. *Do not* use *the term SPM when* diagnosis is *known.*

Core Questions for Follow-up of SPMs:

1. Dates of the underlying disease's diagnosis.
2. Date of first clinical symptoms of SPM.
3. Stage of the underlying disease treated with pomalidomide at baseline, the end of treatment if applicable, and at the time of the event with supportive documentation if available.
4. Medical history of bone marrow transplant including dates, type, donor details, source, and conditioning regimens such as treatment with alkylating agents (i.e. Cyclophosphamide, Melphalan, etc.).
5. Environmental exposure e.g. atmospheric pollutants/toxic chemicals (pesticides, herbicides, benzene, solvents); occupation/hobbies.
6. Full SPM (*specify malignancy or diagnosis if known*) biopsy reports. If not available please provide the detailed results.

In addition to the Core Questions specific information should be requested based on the risk factors for individual types of cancer

Hematologic Malignancies (including Lymphoma and B-cell malignancy):

- Previous chemotherapy rounds (dates, type) and / or radiotherapy (zone, duration, cumulative dose)
- Medical conditions that compromise the immune system – HIV/AIDS, autoimmune diseases, diseases requiring immune suppressive therapy-organ transplant
- For lymphoma: Infection with HIV, Epstein-Barr virus+++, Helicobacter pylori, hepatitis B or C, human T-lymphotrophic virus type I, Burkitt's lymphoma
- Concurrent or medical/family history of inherited syndromes with genetic changes that raise the risk of acute lymphocytic leukemia (ALL) including: Down syndrome, Klinefelter syndrome, Fanconi anemia, Bloom syndrome, Ataxia-telangiectasia, Neurofibromatosis.
- Exposure to benzene (solvent used in the rubber industry, oil refineries, chemical plants, shoe manufacturing, and gasoline-related industries, and is also present in cigarette smoke, as well as some glues, cleaning products, detergents, art supplies, and paint strippers).
- Smoking history – Product smoked (i.e. cigars, cigarettes, etc.) and depth of inhalation, length of time, number of cigarettes/days or pack-years, age at starting
- Exposure to high levels of radiation
- Medical history of treated hematologic malignancies or concurrent leukemias or lymphomas including: Chronic Lymphocytic Leukemia (CLL), Richter transformation, and Diffuse Large B-cell lymphoma (DLBCL) such as Hodgkin's disease and plasmablastic lymphoma.
- Relevant diagnostic test results (if available), including: biopsy, immunohistochemistry, flow cytometry, cytogenetics, reverse transcriptase polymerase chain reaction, Fluorescence in situ hybridization (FISH), and next generation sequencing

Lung Cancer:
- Smoking history - Product smoked (i.e. cigars, cigarettes, etc.) and depth of inhalation, length of time, number of cigarettes/days or pack-years, age at starting
- Pre-existing pulmonary disease
- Family history of lung cancer

Thyroid Cancer:
- Personal or family history of thyroid and/or autoimmune diseases - hypo or hyperthyroidism, goiter, benign thyroid nodules, Hashimoto's disease, Graves disease
- Family history of familial medullary thyroid cancer, multiple endocrine neoplasia and familial adenomatous polyposis
- Living in iodine deficient area
- History of radiation exposure

Breast Cancer:
- Receptor status of the tumor - ER, PR, Her2/neu
- Age at onset of menses and age of menopause
- Number of pregnancies and age at first birth
- History of breastfeeding children
- Use of oral contraceptive or hormone replacement therapy
- Obesity
- Ethnic group, economic status and dietary iodine deficiency

Ovarian Cancer:
- Number of pregnancies and childbearing status
- History of hormone replacement therapy
- History of breast cancer

Uterine Cancer:
- Age at onset of menses and age of menopause
- Number of pregnancies
- Use of oral contraceptives
- Obesity

Colon Cancer:
- Family or personal history of adenomatous polyposis (FAP), Lynch syndrome (Hereditary nonpolyposis colorectal cancer)
- Diet high in red meat and animal fat, refined carbohydrates, low-fiber diet, and low overall intake of fruits and vegetables
- Obesity, and sedentary habits
- Any history of inflammatory conditions of digestive tract - Chronic ulcerative colitis, Crohn's disease longer duration, greater extent of colon involvement

Anorectal Cancer:
- History of infection with human papillomavirus, chronic fistulas, irradiated anal skin, leukoplakia, lymphogranulomatoma venereum, condyloma acuminatum

Gastric Cancer:
- Diet rich in pickled vegetables, salted fish, salt, and smoked meats
- Helicobacter pylori infection
- Obesity
- Previous gastric surgery
- Pernicious anemia, adenomatous polyps, gastric ulcer
- Chronic atrophic gastritis
- Radiation exposure
- History of alcohol use/smoking

Oesophageal Cancer:
- Genetic causes - tylosis (hyperkeratosis palmaris et plantaris)
- Alcohol use/smoking
- History of chronic or acute inflammation (e.g. GERO, Barrett's esophagus, caustic ingestion)Achalasia (esophageal motility disorder)
- Human papilloma virus
- Sclerotherapy
- Plummer-Vinson syndrome (dysphagia, associated with iron deficiency anemia)

Liver cancer:
- History of cirrhosis (including alcoholic, biliary cirrhosis), other chronic liver dysfunction
- History of alcohol use/smoking
- Hepatitis B, C
- Hemochromatosis
- Indigestion of food contaminated with fungal aflatoxins (in subtropical regions)

Pancreatic Cancer:
- History of alcohol use/smoking,
- Obesity
- Diet (red meat)
- History of chronic pancreatitis or long-standing diabetes mellitus (primarily in women)
- Inherited predisposition hereditary pancreatitis, familial adenomatous polyposis)

Renal Cancer (renal cell carcinoma):
- Smoking history – Product smoked (i.e. cigars, cigarettes, etc.) and depth of inhalation, length of time, number of cigarettes/days or pack-years, age at starting
- Obesity
- Hypertension
- Phenacetin-containing analgesics taken in large amounts

- History of renal transplantation
- Exposure to radiopaque dyes, asbestos, cadmium, and leather tanning and petroleum products
- Inherited VHL disease (von Hippel-Lindau disease), Adult polycystic kidney disease, Tuberous sclerosis

Bladder Cancer:
- Smoking history – Product smoked (i.e. cigars, cigarettes, etc.) and depth of inhalation, length of time, number of cigarettes/days or pack-years, age at starting
- Industrial exposure to aromatic amines in dyes, paints, solvents, leather dust, inks, combustion products, rubber, and textiles
- Occupation - painting, driving trucks, and working with metal
- Prior spinal cord injuries with long-term indwelling catheters

Prostate Cancer:
- Smoking history – Product smoked (i.e. cigars, cigarettes, etc.) and depth of inhalation, length of time, number of cigarettes/days or pack-years, age at starting
- History of high-grade prostatic intraepithelial neoplasia (PIN)
- Genome changes-deletion of chromosome 3 and fusion of TMPRSS2 and ERG genes
- Testosterone level
- History of sexually transmitted diseases
- History of vasectomy
- History of exposure to cadmium
- History of genitor-urinary infections

Head and Neck Cancer:
- History of alcohol use/smoking
- Exposure to Human papilloma virus (HPV) or Epstein-Barr virus (EBV)
- History of poor oral hygiene and/or poor nutrition
- Exposure to asbestos, wood dust, paint fumes or chemicals
- History of Gastroesophageal reflux disease (GERD) or laryngopharyngeal reflux disease (LPRD)

Brain tumors (gliomas and meningiomas):
- Exposure to radiation
- Exposure to vinyl chloride, Pesticides
- Immune system disorders
- Hormone replacement therapy

Larynx Cancer:
- History of alcohol use/smoking
- Asbestos exposure
- Any activity requiring loud speech, exposure to sudden and frequent temperature changes
- Frequent hoarseness, frequent and persistent cough

- Persistently swollen neck glands
- Tonsillectomy and laryngeal surgery

Nasal and Paranasal Sinus Cancer:
- Woodworking, any dust/flour chronic exposure
- History of Infection with human papillomavirus (HPV)
- Smoking history – Product smoked (i.e. cigars, cigarettes, etc.) and depth of inhalation, length of time, number of cigarettes/days or pack-years, age at starting

Mouth and Oropharyngeal Cancer:
- History of alcohol use/smoking
- History of poor oral hygiene
- Chronic mucosal/gum irritation / ill-fitting dentures
- Betel-Nut Chewing (Indian populations)
- History of syphilis or viral infections
- Impaired immunity – AIDS, transplant with anti-rejection drugs
- Precancerous mouth plaques – Leukoplakia or erythroplasia
- History of cancer of the aero-digestive tract

Melanoma, basal cell carcinoma, squamous cell carcinoma of skin:
- History of prolonged sun exposure (UV radiation) - severe blistering sunburns, frequent tanning, use of sunlamps and tanning booths
- History of living close to equator or at high elevation
- History of skin conditions - Dysplastic nevus, Xeroderma pigmentosum, nevoid basal cell carcinoma syndromes
- Skin type - fair (pale) skin - burns easily, freckles
- Eye color - blue, green or gray, Hair color - blond or red
- Use of medication causing sensitivity to sun - antibiotics, hormones, antidepressants
- Immune system depression - AIDS, leukemias, etc.
- Exposure to arsenic, coal tar or creosote
- For eye localization: history of oculodermal melanocytosis or Dysplastic nevus syndrome

_____

Health Practitioner Name (Print)

_____

Health Practitioner Name (Signature)

Additional information regarding this Adverse Event Report:

Description of event: [narrative]

REPORTER INFORMATION:

☐ Physician; ☐ Patient; ☐ Other, please specify .....

.....

Name and title: .....

.....

Affiliation: .....

.....

Address: .....

.....

Phone number: ..... E-mail: .....

.....

Date of report (dd/mm/yy): .....

Signature: .....

Pomalidomide – Event-Specific Questionnaire Cardiac Arrhythmia & ECG Changes v1.1

- Supplement to the (S)AE Form -

Follow-up to Case No.:.....

Date of receipt (dd/mm/yyyy):.....

PATIENT INFORMATION:

Age:.....

Gender: ☐ M ☐ F Pregnant: ☐ Y ☐ N

Height ..... cm/ ..... in Weight ..... kg/ ..... lbs

Race/Ethnicity: ☐ Aboriginal ☐ African American ☐ Asian

☐ American Indican or Alaskan Native ☐ Native Hawaiian or other Pacific Islander

☐ Torres Strait Islander ☐ White ☐ Black ☐ Non Hispanic

Age Group: .....

Age Group Definition: Neonate: 0 - 27 days, Infant: 28 days to 23 months, Child: 2 years to 11years, Adolescent: 12 years to 18 years, Adult: More than 18 years and less than or equal to 65 years and Elderly: equal or greater than 66 years)

Suspect Products: Please provide suspect product(s) information [those product(s) that are suspected to be associated with one or more adverse events]:

	Suspect Product #1	Suspect Product #2	Suspect Product #3
Product name			
Daily dose and regimen			
Route of administration			
Indication			
Start date or treatment duration (DD-MMM-YYYY)			
Stop date (DD-MMM-YYYY)			
Lot/Batch number(s)			
Expiration date(s)			
Action Taken with the suspect product			

(Choose from one of the following for action Taken with Suspect Product: Drug withdrawn, Dose reduced, Dose increased, Dose not changed, Unknown)

Adverse Event (AE) Description: Please provide diagnosis or symptoms/signs if diagnosis is unavailable.

	Adverse Event #1	Adverse Event #2	Adverse Event #3	Adverse Event #4
Add Diagnosis Here →				
Start Date (DD/MMM/YYYY)				
Stop Date (DD/MMM/YYYY)				
Time lag if AE occurred after cessation of treatment with the suspect product(s):				
Required Hospitalization (Yes/No)				
Life-Threatening (Yes/No)				
Persistent or significant disability (Yes/No)				
Congenital abnormality (Yes/No)				
Cause of Death (Yes/No)				
Treatment of Adverse Event				
Outcome (recovery and sequelae, if any)				
Did the event(s) abate after suspect Product was stopped or dose reduced? (Yes/No)				
Did the event recur after reintroducing (Yes/No)				

Please summarize course of reported events including signs and symptoms in chronological order:

Diagnostic tests (use additional pages if needed)**:** Please indicate test unit where applicable.

Date	Test Name	Pre-treatment value	AE onset value	AE resolution value	Normal low	Normal high
	CPK					
	CPK-MB					

	Troponin					
	RBC					
	Hemoglobin					
	Metabolic Panel (specify)					
	Serum potassium					
	Serum magnesium					
	Phosphorus					
	Calcium					
	Uric acid					
	Creatinine					
	BUN					

Please provide causal relationship assessment between the suspect product(s) and adverse event(s):

Concomitant Medications (use additional pages if needed):

Did the Patient take any concomitant medication? ☐ Yes (please complete below) ☐ None ☐ Unknown

Please include any antiemetics.

Medication Name	Daily dose and regimen	Route of administration	Indication	Start date DD-MMM-YYYY	Stop date DD-MMM-YYYY

Other Etiological Factors: ☐ Yes (please complete below) ☐ None ☐ Unknown

☐ Relevant medical and/or drug history (please specify), including start date or duration:

☐Family history (please specify)

☐Drug/alcohol/tobacco abuse

☐Other (please specify)

Additional questions:

Please provide brief description of the cardiac arrhythmia, or ECG change, including the type and the clinical signs/symptoms observed, including start and stop dates:

- Type of arrhythmia/ECG change

- Clinical signs and symptoms, if present (if none please state)

Start date ..... Stop date.....

Does this patient have a relevant cardiac history? If yes, please specify. If no, please state.

Does this patient have a history of cardiac risk factors (e.g. hypertension, hyperlipidemia, hypercholesterolemia, diabetes, sepsis, obesity, smoking, renal disease, cardio respiratory problems)? If yes, please specify below. If no, please state.

Please provide the available results of the diagnostic workup (include dates of baseline, event onset, and resolution results)

Test	Pre-treatment results	AE onset results	AE resolution results
ECG findings			
Echocardiogram			
Chest x-ray			
Holter, Stress Test			

Please describe specific treatments and interventions of the arrhythmia

_____

Health Practitioner Name (Print)

_____

Health Practitioner Name (Signature)

Additional information regarding this Adverse Event Report:

Description of event: [narrative]

REPORTER INFORMATION:

☐ Physician; ☐ Patient; ☐ Other, please specify .....

.....

Name and title: .....

.....

Affiliation: .....

.....

Address: .....

.....

Phone number: ..... E-mail: .....

.....

Date of report (dd/mm/yy): .....

Signature: .....

Annex 6 – Details Of Proposed Additional Risk Minimisation Activities (If Applicable)

The MAH shall agree the details of a controlled access programme with the National Competent Authorities and must implement such programme nationally to ensure that:

Prior to prescribing (where appropriate, and in agreement with the National Competent Authority, dispensing) all healthcare professionals who intend to prescribe (and dispense) pomalidomide are provided with an Educational Healthcare Professional's Kit containing the following:

- Educational Healthcare Professional brochure
- Educational brochures for patients
- Patient card
- Risk awareness forms
- Information on where to find latest Summary of Product Characteristics (SmPC)

The MAH shall implement a pregnancy prevention programme (PPP) in each Member State.

Details of the PPP should be agreed with the National Competent Authorities in each Member State and put in place prior to the launch of the medicinal product.

The MAH should agree the final text of the contents of the Educational Healthcare Professional's Kit with the National Competent Authority in each Member State prior to launch of the medicinal product and ensure that the materials contain the key elements as described below.

The MAH should agree on the implementation of the controlled access programme in each Member State.

Key elements to be included

The Educational Healthcare Professional's Kit

The Educational Health Care Professional's Kit shall contain the following elements:

- Educational Healthcare Professional brochure

- Brief background on pomalidomide and its licensed indication
- Maximum duration of treatment prescribed according to the approved indications dosing regimens
    - 4 weeks for women with childbearing potential
    - 12 weeks for men and women without childbearing potential
- The need to avoid foetal exposure due to teratogenicity of pomalidomide in animals and the expected teratogenic effect of pomalidomide in humans
- Guidance on handling the blister or capsule of Pomalidomide Teva for healthcare professionals and caregivers
- Obligations of the health care professional who intend to prescribe or dispense pomalidomide

  - Need to provide comprehensive advice and counselling to patients
  - That patients should be capable of complying with the requirements for the safe use of pomalidomide
  - Need to provide patients with appropriate patient educational brochure, patient card and/or equivalent tool
- Safety advice relevant to all patients
  - Description and management of thrombocytopenia including incidence rates from clinical studies
  - Description and management of cardiac failure
  - That any unused capsules should be returned to the pharmacist at the end of the treatment
  - Local country specific arrangements for a prescription for pomalidomide to be dispensed
  - That the patient should not donate blood during treatment (including during dose interruptions) and for at least 7 days following discontinuation of pomalidomide
- Description of the PPP and categorisation of patients based on sex and childbearing potential
  - Algorithm for implementation of PPP
  - Definition of women of childbearing potential (WCBP) and actions the prescriber should take if unsure
- Safety advice for women of childbearing potential
  - The need to avoid foetal exposure
  - Description of the PPP
  - Need for effective contraception (even if woman has amenorrhoea) and definition of effective contraception
  - That if she needs to change or stop using her method of contraception she should inform:
    - The physician prescribing her contraception that she is on pomalidomide
    - The physician prescribing pomalidomide that she has stopped or changed her method of contraception
  - Pregnancy test regime
    - Advice on suitable tests
    - Before commencing treatment
    - During treatment based on method of contraception
    - After finishing treatment
  - Need to stop pomalidomide immediately upon suspicion of pregnancy
  - Need to tell treating doctor immediately upon suspicion of pregnancy
- Safety advice for men
  - The need to avoid foetal exposure
  - The need to use condoms if sexual partner is pregnant or a WCBP not using effective contraception (even if man has had a vasectomy)
    - During pomalidomide treatment
    - For at least 7 days following final dose
  - That he should not donate semen or sperm during therapy (including during dose interruptions) and for at least 7 days after discontinuation of pomalidomide treatment

  - That if his partner becomes pregnant whilst he is taking pomalidomide or shortly after he has stopped taking pomalidomide he should inform his treating doctor immediately
- Requirements in the event of pregnancy
  - Instructions to stop pomalidomide immediately upon suspicion of pregnancy, if female patient
  - Need to refer patient to physician specialised or experienced in dealing with teratology and its diagnosis for evaluation and advice
  - Local contact details for reporting of any suspected pregnancy immediately
- Local contact details for reporting adverse event.

Educational Brochures for patients

The Educational brochures for patients should be of 3 types:

- Brochure for women patients of childbearing potential and their partners
- Brochure for women patients who are not of childbearing potential
- Brochure for male patients

All educational brochures for patient should contain the following elements:

- That pomalidomide is teratogenic in animals and is expected to be teratogenic in humans
- That pomalidomide may cause thrombocytopenia and the need for regular blood tests
- Description of the patient card and its necessity
- That any unused capsules should be returned to the pharmacist at the end of the treatment
- Guidance on handling pomalidomide for patients, caregivers and family members
- National or other applicable specific arrangements for a prescription for pomalidomide to be dispensed
- That the patient should not give pomalidomide to any other person
- That the patient should not donate blood during therapy (including during dose interruptions) and for at least 7 days after discontinuation of pomalidomide treatment
- That the patient should tell their doctor about any adverse events

The following information should also be provided in the appropriate brochure:

Brochure for women patients with childbearing potential

- The need to avoid foetal exposure
- Description of the PPP
- Need for effective contraception and definition of effective contraception
- That if she needs to change or stop using her method of contraception she should inform:
  o The physician prescribing her contraception that she is on pomalidomide
  o The physician prescribing pomalidomide that she has stopped or changed her method of contraception
- Pregnancy test regime
  - Before commencing treatment
  - During treatment (including dose interruptions), at least every 4 weeks except in case of confirmed tubal sterilisation

    - After finishing treatment
- The need to stop pomalidomide immediately upon suspicion of pregnancy
- The need to contact their doctor immediately upon suspicion of pregnancy

Brochure for male patients

- The need to avoid fetal exposure
- The need to use condoms if sexual partner is pregnant or a WCBP not using effective contraception (even if man has had vasectomy)
    - During pomalidomide treatment (including dose interruptions)
    - For 7 at least days following final dose
- That if his partner becomes pregnant, he should inform his treating doctor immediately
- That he should not donate semen or sperm during therapy (including during dose interruptions) and for 7 days after discontinuation of pomalidomide treatment

Patient Card or equivalent tool

The patient card shall contain the following elements:

- Verification that appropriate counselling has taken place
- Documentation of childbearing status potential
- Check box (or similar) which physician ticks to confirm that patient is using effective contraception (if woman of childbearing potential)
- Pregnancy test dates and results

Risk Awareness Forms

There should be 3 types of risk awareness forms:

- Women of childbearing potential
- Women of non-childbearing potential
- Male patient

All risk awareness forms should contain the following elements:
- teratogenicity warning
- patients receive the appropriate counselling prior to treatment initiation
- affirmation of patient understanding regarding the risk of pomalidomide and the PPP measures
- date of counselling
- patient details, signature and date
- prescriber name, signature and date
- aim of this document i.e. as stated in the PPP: “The aim of the risk awareness form is to protect patients and any possible foetuses by ensuring that patients are fully informed of and understand the risk of teratogenicity and other adverse reactions associated with the use of pomalidomide. It is not a contract and does not absolve anybody from his/her responsibilities with regard to the safe use of the product and prevention of foetal exposure.”

Risk awareness forms for women of childbearing potential should also include:

- Confirmation that the physician has discussed the following:
    - the need to avoid foetal exposure

- that if she is pregnant or plans to be, she must not take pomalidomide
- that she understands the need to avoid pomalidomide during pregnancy and to apply effective contraceptive measures without interruption, at least 4 weeks before starting treatment, throughout the entire duration of treatment, and at least 4 weeks after the end of treatment
- that if she needs to change or stop using her method of contraception she should inform:
    - the physician prescribing her contraception that she is taking pomalidomide
    - the physician prescribing pomalidomide that she has stopped or changed her method of contraception
- of the need for pregnancy tests i.e. before treatment, at least every 4 weeks during treatment and after treatment
- of the need to stop pomalidomide immediately upon suspicion of pregnancy
- of the need to contact their doctor immediately upon suspicion of pregnancy
- that she should not share the medicinal product with any other person
- that she should not donate blood during treatment (including during dose interruptions) and for at least 7 days following discontinuation of pomalidomide
- that she should return the unused capsules to the pharmacist at the end of treatment

Risk awareness forms for women with no childbearing potential should also include:

- Confirmation that the physician has discussed the following:
    - that she should not share the medicinal product with any other person
    - that she should not donate blood during treatment (including during dose interruptions) and for at least 7 days following discontinuation of pomalidomide
    - that she should return the unused capsules to the pharmacist at the end of treatment

Risk awareness forms for male patients should also include:

- Confirmation that the physician has discussed the following:
    - the need to avoid foetal exposure
    - that pomalidomide is found in semen and the need to use condoms if sexual partner is pregnant or is a WCBP not on effective contraception (even if the man has had a vasectomy)
    - that if his partner becomes pregnant, he should inform his treating doctor immediately and always use a condom
    - that he should not share the medicinal product with any other person
    - that he should not donate blood or semen during treatment (including during dose interruptions) and for at least 7 days following discontinuation of pomalidomide
    - that he should return the unused capsules to the pharmacist at the end of treatment