Pregnancy Test Results Form (for WCBP – women of childbearing potential)

This form is to be sent to Neopharm at time of prescription registeration!

Date:

Product Name:

☐ **Thalidomide (BMS)**

☐ **Imnovid (Pomalidomide)**

Patient's initials (First name, Last name): _____

Patient's ID number: _____

Date of visit	Date of receiving a **negative** pregnancy test result	Confirmation that there is no risk of pregnancy (**please check**)	Date of prescription for Thalidomide BMS/Imnovid	Prescriber's signature

Name of the medical institution: _____

Name of the prescriber: _____

License number of the prescriber: _____

Send this form to Neopharm via fax number 03-9264237 or via email to the following address: RMP@neopharmisrael.com

This document was last approved in Apr/2025 by the Israeli Ministry of Health (MOH)