This material was developed by Dr. Reddy's Laboratories, as part of the risk minimization plan for Reddy-Lenalidomide and Reddy-Pomalidomide. This material is not intended for promotional use.

Reddy-Lenalidomide RMP Program and Reddy-Pomalidomide RMP Program: Pregnancy Report Form

Please complete this form to report an identified pregnancy exposure (whether the exposure was via the patient or partner) treated with Reddy-Lenalidomide or Reddy-Pomalidomide. Please send immediately to Dr. Reddy's Laboratories, Inc. Contact details are given below.

As part of the Reddy-Lenalidomide RMP Program and Reddy-Pomalidomide RMP Program, it is essential that we follow-up on all reported pregnancies. Dr. Reddy's will therefore be in contact with you for further information in due course and would value your cooperation to ensure we are able to obtain all relevant details on identified fetal exposure to Reddy-Lenalidomide or Reddy-Pomalidomide.

Adverse Event Reporting
REPORTING TO **REDDY-LENALIDOMIDE RMP PROGRAM AND REDDY-POMALIDOMIDE RMP PROGRAM CONTACT CENTER:**

Attn: Reddy2Assist Program
5155 Spectrum Way, Unit 29,
Mississauga ON L4W 5A1
Phone: 1-877-938-0670
Fax: 1-877-938-0807
Email: reddy2assist@drreddys.com
Website: www.reddy2assist.com

Dr.Reddy's

PREGNANCY REPORT FORM

REPORTER INFORMATION

Reporter Name:

Address: **Occupation:**

Phone Number: **Email Address:**

PATIENT EXPOSURE INFORMATION: Please fill out relevant section, as applicable

FEMALE PATIENT TAKING TREATMENT MEDICATION	FEMALE PARTNER OF MALE PATIENT TAKING TREATMENT MEDICATION
Patient ID: _____	**Female Partner Date of Birth: _____**
Date of Birth: _____	**Female Partner Age: _____**
Age: _____	**Male Patient ID: _____**
	Male Patient Date of Birth: _____
	Male Patient Age: _____

PATIENT TREATMENT INFORMATION:

Name of the treatment (select appropriate option):

☐ **REDDY-LENALIDOMIDE CAPSULE** ☐ **REDDY-POMALIDOMIDE CAPSULE**

Indication for Use: _____

Lot Number: _____ Expiry Date: _____ Dose:_____ Frequency:_____

Start Date: _____ Stop Date: _____

FOLLOW-UP OF THE PREGNANCY

	Yes	No
Has the patient already been referred to an Obstetrician/Gynecologist?		

If yes, please specify his/her name and contact details:

REASON FOR FAILURE OF PREGNANCY PREVENTION PROGRAM		
	Yes	**No**
Was patient erroneously considered not to be of child-bearing potential?		
If yes, state reason for considering not to be of child-bearing potential		
a. Age ≥ 50 years and naturally amenorrheic for ≥ 12 consecutive months (excluding amenorrhea following cancer therapy), had a hysterectomy, and/or had bilateral oophorectomy		
b. Premature ovarian failure confirmed by a specialist gynecologist		
c. XY genotype, Turner's syndrome, uterine agenesis.		
Indicate from the list below what contraception was used	**Yes**	**No**
a. Intrauterine device (IUD)		
b. Hormonal methods (birth control pills, hormonal patches, injections, vaginal rings, or implants		
c. Partner's vasectomy		
d. Tubal ligation		
e. Male latex or synthetic condom		
f. Diaphragm		
g. Cervical cap		
h. Progesterone-only "mini-pills"		
i. IUD Progesterone T		
j. Female condom		
k. Natural family		
l. Planning (rhythm method) or breastfeeding		
m. Fertility awareness		
n. Withdrawal		
o. Cervical shield		
p. None		
q. Other _____		
Indicate from the list below the reason for contraceptive failure	**Yes**	**No**
Missed oral contraception		
Other medication or intercurrent illness interacting with oral contraception		
Identified mishap with barrier method		
Unknown		
Did the patient commit to complete and continuous abstinence?		
Was Reddy-Lenalidomide or Reddy-Pomalidomide started despite patient already being pregnant?		
Did patient receive educational materials on the potential risk of teratogenicity?		
Did patient receive instructions on need to avoid pregnancy?		

PRENATAL INFORMATION		
Date of last menstrual period:	**Estimated Delivery Date**:	**Pregnancy Termination Date:**
Pregnancy test	**Reference range**	**Date**
Urine Qualitative		
Serum quantitative		

PAST OBSTRETRIC HISTORY						
	Outcome					
Year of pregnancy	**Spontaneous abortion**	**Therapeutic abortion**	**Live birth**	**Still birth**	**Gestational Age**	**Type of delivery**

BIRTH DEFECTS			
	Yes	**No**	**Unknown**
Was there any birth defect from any pregnancy?			
Is there any family history of congenital abnormality?			
If yes to either of these questions, please provide details below			

MATERNAL PAST MEDICAL HISTORY				
Condition	**Dates**		**Treatment**	**Outcome**
	From	**To**		

MATERNAL CURRENT MEDICAL CONDITIONS		
Condition	**From**	**Treatment**

MATERNAL SOCIAL HISTORY		
	Yes	**No**
Alcohol		
If yes, amount/units per day:		

Tobacco		
If yes, amount per day:		
IV or recreational drug use		
If yes, provide details		

MATERNAL MEDICATION DURING PREGNANCY AND IN 4 WEEKS BEFORE PREGNANCY
(including herbal, alternative and over the counter medicines and dietary supplements)

Medication/treatment	Start Date	Stop Date/ Continuing	Indication

Any relevant information to include:

NAME OF PERSON COMPLETING THIS FORM	SIGNATURE	DATE