Draft Version – out of date as of 23 June 08

Lucentis®▼(ranibizumab) Dose Capping Scheme
Pharmacy Dispensing Form

Unique Novartis Number: xxxxxxxx

Hospital Name:……PCO name (if applicable):…….

Patient Hospital Identifier: …….Name of responsible person:……

Treating Consultant:……..……..Contact Number:……

Lucentis treatment start date……. e-mail address:……...

Please complete below for each individual patient and eye. Each Lucentis vial up to and including dose 14 is required to be documented and signed by the responsible clinician/pharmacist in order to validate claims for treatments 15 and beyond:

Left eye

Loading Dose Regime

Vial 1. Batch Number: ……

Date: ……..

Signature: ……

Vial 2. Batch Number: ……

Date: ……..

Signature: ……

Vial 3. Batch Number: ……

Date: ……..

Signature: ……

Vial 4 Batch Number: ……

Date: ……Signature:……

Vial 5 Batch Number: ……

Date: ……Signature:……

Vial 6 Batch Number: ……

Date: ……Signature:……

Vial 7 Batch Number: ……

Date: ……Signature:……

Right eye

Loading Dose Regime

Vial 1. Batch Number: ……..

Date: ……..

Signature: ……

Vial 2. Batch Number: ……

Date: ……..

Signature: ……

Vial 3. Batch Number: ……

Date: ……..

Signature: ……

Vial 4 Batch Number: ……

Date: ……Signature:……

Vial 5 Batch Number: ……

Date: ……Signature:……

Vial 6 Batch Number: ……

Date: ……Signature:……

Vial 7 Batch Number: ……

Date: ……Signature:……

Vial 8 Batch Number: ……

Date: ……Signature:……

Vial 9 Batch Number: ……

Date: ……Signature:……

Vial 10 Batch Number: ……

Date: ……Signature:……

Vial 11 Batch Number: ……

Date: ……Signature:……

Vial 12 Batch Number: ……

Date: ……Signature:……

Vial 13 Batch Number: ……

Date: ……Signature:……

Vial 14 Batch Number: ……

Date: ……Signature:……

Vial 8 Batch Number: ……

Date: ……Signature:……

Vial 9 Batch Number: ……

Date: ……Signature:……

Vial 10 Batch Number: ……

Date: ……Signature:……

Vial 11 Batch Number: ……

Date: ……Signature:……

Vial 12 Batch Number: ……

Date: ……Signature:……

Vial 13 Batch Number: ……

Date: ……Signature:……

Vial 14 Batch Number: ……

Date: ……Signature:……

Please complete claim form for reimbursement after administration of dose 14

Please complete claim form for reimbursement after administration of dose 14

I confirm that I am an authorised person within the hospital/trust and this claim is in accordance with the SmPC for ranibizumab as well as the terms and conditions of the Lucentis Dose Capping Scheme Agreement:

Name

Signature

Date

By post, please send to: Novartis Customer Services Department, Novartis Pharmaceuticals UK Limited Frimley Business Park, Frimley, Camberley, Surrey, GU16 7SR.

Fax: ……..

e-mail: …….

I confirm that I am an authorised person within the hospital/trust and this claim is in accordance with the SmPC for ranibizumab as well as the terms and conditions of the Lucentis Dose Capping Scheme Agreement:

Name

Signature

Date

By post, please send to: Novartis Customer Services Department, Novartis Pharmaceuticals UK Limited, Frimley Business Park, Frimley, Camberley, Surrey, GU16 7SR.

Fax: ……..

e-mail: …….

Should you need any further information regarding the Lucentis Dose Capping Scheme, please call our Customer Services Team on ……..

Further information on the Lucentis Dose Capping Scheme is also available on www.lucentis.co.uk

For Novartis Pharmaceuticals UK Limited Use: Novartis Approved: Approved/Non-Approved Date Received: If Non-approved, add reason:	For Novartis Pharmaceuticals UK Limited Use: Novartis Approved: Approved/Non-Approved Date Received: If Non-approved, add reason:

LUCENTIS PRESCRIBING INFORMATION
Item prepared: January 2008-01-13
Job Bag Number: