AVM BIOTECHNOLOGY

Compassionate Use Application

Please complete this form and have the treating physician sign it. Please send to AVM Biotechnology E-mail: **compassionateuse@avmbiotech.com**

We will review the request and respond as soon as possible. Most applications process within 48hrs. If you require immediate or emergent use, please notify us.

PATIENT INFORMATION

Patient Name:

Current Diagnosis You Are Requesting Expanded Use For:

Age: Diagnosis Date:

Previous Treatments: Last Treatment Date:

Current Weight: Current Height:

Proposed Route of Drug Administration: ◯ IV Proposed Dosage in mg/kg:

LICENSED PHYSICIAN REQUESTING INFORMATION

Name: Specialty:

Licensed in Which State or Country: License Number:

Office Address: Office Phone:

Physician E-mail: Key Contact Person Name:

Key Contact Phone: Key Contact E-mail:

Where would you prefer to have the letter of authorization e-mailed?: ◯ Physician ◯ Key Contact

***Please attach physician's curriculum vitae**

LOCATION OF TREATMENT (this is the location where the drug will be shipped)

Current Location of Patient: ◯ Hospital ◯ Extended Care ◯ Home

Address of Current Location: _____

Phone of Current Location: _____ Key Contact Name at Location: _____

Key Contact Phone: _____ Key Contact E-mail: _____

Proposed Treatment Date: _____ Date You Would Like the Drug Delivered: _____

QUESTIONS (to be completed by the treating physician)

Has the patient exhausted approved therapeutic options? ◯ Yes ◯ No

Is the patient eligible to enroll and able to participate in a clinical trial or EAP? ◯ Yes ◯ No

Do you as a licensed physician treating this patient for the current diagnosis feel that there are therapeutic benefits of the drug under investigation for this patient? ◯ Yes ◯ No

Do you believe that the therapeutic benefits outweigh the potential risks of this drug under investigation for this patient? ◯ Yes ◯ No

As the requesting physician, you must also complete the following steps before we can ship:

Have you completed FDA form 3926? ◯ Yes ◯ No

Have you contacted your IRB for review? ◯ Yes ◯ No
If not, are you requesting Alternative IRB Review? ◯ Yes ◯ No

Have you discussed the potential of participating in this program with the patient or representative? ◯ Yes ◯ No

In addition, you are required to report any adverse events to the FDA as well as AVM Biotechnology, LLC., using standard acceptable forms of reporting as required by the FDA (Use **FDA Form 3500A** together with **Form 1571**). You are also required to report the outcome of the treatment within 5 working days to your IRB as well as any adverse event you believe is due to the use of this treatment in an annual report. Do you agree to these requirements?
◯ Yes ◯ No

Signature of Requesting Physician: _____

Date: _____