

Appendix 1 – FORM A: Patient Registration & Request for Supply Form

Send to [Distributor Address]

[Insert Drug name]

HOSPITAL DETAILS:

Requesting Doctor's Name:
Hospital Name:
Address:
Postcode

HOSPITAL REF NO. (IF APPLICABLE)

Contact Name:
Position:
Tel No:

I request a supply of [Insert Drug name] for the following patient:-

Patient Initials: **Sex M/F:** **D.o B:**
D D / M M M / Y Y Y Y

Is this a NEW request or a RESUPPLY request for NEW or RESUPPLY (please circle)

Dosage: Micrograms / day

Number of Bottles : 1 mL (please circle):
5 mL (please circle):

Date Required:

Is this patient completing an Eisai Clinical Trial? Yes No

If yes, state the Eisai trial number:

Indication and relevant medical history and concomitant medications:

MEDICAL PRACTITIONER

I consider [Insert Drug name] to be an appropriate treatment for this patient given his/her current clinical condition and also taking into account previous and existing medication.

I will immediately report ALL Suspected Adverse Drug Reactions to Eisai.

I agree to settle any requested payment that has been agreed to in advance of signing this agreement

I accept full responsibility and liability for the treatment of this patient with [Insert Drug name]

Name: _____ Signature: _____
 Position: _____ Date: _____

FOR EISAI USE ONLY: MEDICAL AFFAIRS
 (NOTE ALL INITIAL REQUESTS NEED EISAI MEDIC APPROVAL)

Approved by:
 Name:
 Signature:
 Date:

FOR DISTRIBUTOR USE ONLY: MEDICAL AFFAIRS

Date request received:
D D / M M M / Y Y Y Y

Date sent to Eisai :

Database entry and dispatch to Supplier:

Name: _____ Signature: _____
 Date: _____

ALLOCATED PATIENT SUPPLY NO.:

FOR SUPPLIER USE ONLY