***This form is to be completed and signed by Requesting Physician***

**PART A.**

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| **EAP Request Details** |
| **Contact Information** |
| **1.** Name of requestor/physician: |
| **2.** Name of institution (if applicable): |
| **3.** Physician/institution address (where drug supply will be delivered to if approved): |
| **4.** Physician phone number: |
| **5.** Physician email: |
| **Proposal Information *(Please do not include any identifiable patient information)*** |
| **6.** Name of investigational drug(s) being requested: |
| **7.** Description of patient disease or condition:  See attached. *(including any relevant history and/or biomarker information)* |
| **8.** Please describe proposed treatment plan to include dose and duration:  See attached. |

**PART B.**

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| **Physician Attestation** |

**Expanded Access Program  
Physician Attestation & Conditions for Supply**

* I am a physician duly licensed and authorized to practice medicine in the jurisdiction where the investigational drug(s) will be administered (please provide a copy of your CV and medical license).
* I attest that treatments to the disease have been exhausted and the patient is no longer responsive to, or able to tolerate, these therapies and there are currently no other viable therapy options, including participation in ongoing relevant clinical trials.
* I acknowledge and agree that the investigational drug(s) will be supplied solely for use by the patient who is the subject of this request and for no other purpose and for use under my direct supervision.
* I agree that I, not Arcus, am responsible for all regulatory obligations associated with this request and my patient’s use of the investigational drug(s).
* Prior to the first administration of investigational drug, I will inform my patient of the risks associated with the investigational drug(s), including that it has not been approved in this country, and will obtain his/her informed consent (or that of his/her legally acceptable representative) in accordance with applicable laws and regulations.
* I will ensure that the informed consent authorizes the collection of my patient’s health information and transfer to and use by Arcus, its collaborators, service providers and others in connection with their development and commercialization of the investigational drug(s).
* I will obtain any required approvals from and/or make any required notifications to governmental authorities and/or institutional review board/independent ethics committee applicable to the use of the investigational drug(s) for my patient and will notify Arcus immediately if any such approvals are withdrawn, suspended or revoked. I acknowledge that Arcus will not supply any investigational drug(s) until documentation of such approvals or notices have been provided.
* I will further provide Arcus with copies of any material correspondence with any such governmental authorities and/or institutional review board/independent ethics committee relating to the use of the investigational drug(s) for my patient, including any annual updates or final summary at the conclusion of the treatment with the investigational drug(s).
* I agree to report, via email to [ArcusPV@ubc.com](mailto:ArcusPV@ubc.com) within the timelines below, all adverse events associated with use of the investigational drug(s), regardless of causality, by providing a copy of the original CIOMS I or MedWatch form submitted to the applicable regulatory authority:
* All initial fatal or life-threatening suspected unexpected serious adverse reactions: within 5 calendar days
* All follow-up fatal or life-threatening suspected unexpected serious adverse reactions: within 10 calendar days
* All non-fatal or non-life-threatening serious adverse drug reactions: within 10 calendar days
* Pregnancy reports (inclusive of partner pregnancy): within 30 calendar days
* All other serious adverse events: within 30 calendar days
* I will maintain the confidentiality of information provided about the investigational drug(s) and disclose or disseminate such information only as required by law or regulation or as authorized by Arcus.
* I agree that Arcus may use data and results generated as a result of the administration of the investigational drug(s) for any purpose in accordance with applicable laws, and that Arcus will own all resulting patent or other intellectual property rights.
* I will submit any planned publication material to Arcus prior to submission, for Arcus’s review and approval.
* I will inform Arcus when my patient discontinues treatment with the requested investigational drug(s). I acknowledge and agree that Arcus may discontinue supply of an investigational drug if Arcus terminates development of such investigational drug or it becomes approved for use in this country.
* I am familiar with, understand, and agree to comply with all applicable laws and regulations relating to the pre-approval use of investigational drugs.
* I certify with my signature, that I have read, understood, and accept the above terms.

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| Physician Name: | Institution Name: |
| Physician Signature: | Date: |

**HISTORY OF REVISIONS**

| **Effective Date** | **Version** | **Author** | **Description of Changes** |
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| 24-Nov-2020 | 1.0 | Nick Giafis | New document. |