SANOFI Foundation for North America

U.S. Campath Distribution Program (CDP)
Medical Review Form

Please complete all fields. Incomplete information may delay your request.

Additional Information for Medical Review			
Patient Initials and DOB:		**Prescriber Address:**	
Prescriber Name:		**Prescriber State License Number:**	

Please initial to confirm that the patient has a condition for which conventional therapies have failed, are unsuitable or are unavailable either as marketed products or through enrollment into clinical trials. Patients not meeting these criteria may not be eligible for access.	**Please Initial**

Please provide the patient's current diagnosis for which you are seeking therapy with Campath:			
Please provide patient's current disease status:			
Planned Campath Dosage		**Planned Treatment Schedule**	
Do you intend to use Campath in combination with other therapies? If yes, please indicate:		**Yes [ ], please specify regimen:** **No [ ]**	
Did the patient receive any prior therapies to treat the above condition? **If yes, please indicate regimens previously used to treat the above condition:**			**Yes [ ]** **No [ ]**
Prior Therapy Regimens:	**Dates of Prior Therapy:**	**Response:**	**Duration of Response:**

Please provide additional information that should be considered in review of this request for Campath:

Please fax completed form to 800.513.1824

If you have any questions please contact:
Campath Distribution Program
877.422.6728
Monday through Friday, 9:00 AM to 8:00 PM EST.

CAM-US-P009-0712