Treatment IND Information Sheet

Complete this form electronically and then **email completed requests to:** mrugani1@fairview.org
You may also fax completed forms to (612) 672-7691.

If you have any questions or concerns regarding this form or your requested data report, please contact Mike Rugani in Fairview Research Administration at (612) 672-7680.

Date of Application:

1. Physician's Contact Information

Name:

Phone: Email:

2. IRB Information

Study title *(may use acronym or short version)*:

Principal Investigator:

Study IRB approval status:

☐ Not submitted yet ☐ Submitted, pending approval ☐ Approved, HSC#

2. Ongoing Clinical Trials

Are you aware of any ongoing clinical trials using the drug?

Identify the study(ies):

What is/are the ClinicalTrials.gov identifier(s)?

4. Drug Information

Sponsor is providing the investigational drug free of charge to the study site?: ☐ Yes ☐ No
If yes, do not complete the rest of this form, and submit per the instructions above.
If no, please complete sections 3 through 7 prior to submission.

Name of Drug:

IND #:

What is the ClinicalTrials.gov identifier?

Who is the Sponsor?

Is the Sponsor Seeking FDA Approval for the Drug?: ☐ Yes ☐ No

Anticipated Number of Patients Receiving the Drug Annually:

Intended Population(s): ☐ Adult Patients ☐ Pediatric Patients

Location(s) for use (list hospital or clinic where use will occur):

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5. Rationale for Use

Provide a brief summary of the rationale for use of this drug:

6. Alternative Therapies

Describe any alternative therapies:

7. Efficacy Data

Summarize efficacy data:

8. Additional Comments

If applicable, include any additional comments regarding your request that we may need to know:

9. Additional Documentation

Attach a copy of the protocol