EXPANDED ACCESS PROGRAM REQUEST FORM

Please fill out the requested information below and submit to: expandedaccess@biocryst.com

PATIENT INFORMATION		
Age	**Gender**	**Country**

PHYSICIAN INFORMATION	
Name	**Institution**
Country of Medical Practice	**Contact Information**

PATIENT DIAGNOSIS AND TREATMENT HISTORY	
Diagnosis	**Date of Diagnosis**
Previous Treatments	**Current Treatment Plan**

DRUG INFORMATION REQUESTED	
Drug Name	**Proposed Dosage and Administration**
Proposed Treatment Duration	

JUSTIFICATION FOR REQUEST	
Rationale for Request	
Why Standard Treatments Are Not Suitable	
Expected Benefits	**Potential Risks**