Expanded Access Submission Form

1. Contact Information

Physician Name	
Physician Email	
Physician Phone Number	
Research Site Name	
Research Site Address	
Additional Contact Names/Titles/Email Addresses (if needed)	

2. Additional Site Information ☐ Not applicable

Research Site Name	
Research Site Address	

Research Site Name	
Research Site Address	

3. Patient Information

Patient Initials	
Diagnosis	
Is Patient eligible to participate in a Ziopharm sponsored or other clinical trial (Y/N)?	
Patient has undergone appropriate standard treatments without success, or no standard treatment exists for the disease or condition? (Y/N)	
Benefit/Risk Assessment	

Patient agrees to provide written informed consent regarding the benefits versus risks associated with the treatment (Y/N)?	
Previous Treatments/Outcome (or no standard treatment exists for the disease or condition)	
Concomitant Medication	
Relevant Medical History and co-existing conditions	
Patient age, weight, height	
Recent lab results if available (attach if needed)	
Investigational Product Requested, including quantity and dosing details	
Financial Support Requested (please provide detailed budget) if needed	
Type of Request	☐ **Standard Expanded Access** ☐ **“Right to Try”**
Rationale for Request	

4. **Physician Credentials**

   A. Please check that the following documents have been provided:

Signed CDA (if not already in place)	
Current signed CV	
Current Medical License	
Evidence of site affiliation/ hospital privileges	
Documentation of GCP Training (within 2 years)	
Evidence of medical liability insurance (if required by local laws)	

B. Please complete the following questions:

How many years has the Physician been conducting clinical research?	
Has the Physician been subject to an audit by the FDA or other regulatory agency within the past two years? If yes, please provide any findings.	
Has the Physician or other member of the research staff been debarred or disciplined by the FDA or other regulatory agency?	

5. Physician Signature

The signature below indicates that the information provided on this form is true and accurate to the best of my knowledge.

____ ______________________________

Physician Signature **Date**

Please submit form via email to:
Expandedaccess@ziopharm.com