



**CATEGORY B FORM SPECIAL ACCESS SCHEME**  
**PLEASE USE BLACK PEN, PRINT CLEARLY AND COMPLETE ALL SECTIONS**

**Patient details**

Patient's initials:	DOB:
MRN:	SEX:
Diagnosis	Previous SAS No. (if applicable)
Clinical justification for use of product <i>Include appraisal of seriousness of patient's condition; detail previous treatments and expected benefits from use of the product</i>	

**Product details** *Attach efficacy and safety data to support proposed use of the product and details of intended monitoring.  
 \*Complete for medicines and biologicals only.*

Active* ingredient	Trade name /Device name
Company/supplier (State if imported)	
Dose form*	Route of administration*
Dosage* (dose x frequency)	Duration of treatment
Date of medical device/ biological procedure/use	

**Prescribing doctor details**

Name <i>Initial Surname</i>	Hospital
Postal address (hospital or private). The approval letter will be mailed to this address.	Department
	Phone
<i>Postcode</i>	Fax number
Signature & date	/ /