Please e-mail or fax the completed form to the following details

UK Enquiries:
Tel - +44 (0) 1932 824100
Fax +44 (0) 1932 824300
Email: customerservices@idispharma.com

International Enquiries:
Tel - +44 (0) 1932 824123
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Email: customerservices@idispharma.com

Defibrotide Access Form

I would like to obtain Defibrotide for the following patient:

Patient Identifier:	Clinical indication: ☐ Treatment of Veno-Occlusive Disease ☐ Prevention of Veno-Occlusive Disease Other (please state) ………………………..
Gender:	
Date of Birth:	
Type of Stem Cell Transplantation: ☐ Allogeneic ☐ Autologous Other (please state) ……………………….. ☐ VOD not due to stem cell transplant	Date of Transplant:

Please send Defibrotide for the above patient

Inclusion Criteria

For Treatment of VOD:
Two or more of the following features (Modified Seattle Criteria): Bilirubin > 2 mg/dL (34,2 µmol/l), hepatomegaly and right upper quadrant pain, ascites and/or unexplained weight gain >2%.

For Prevention of VOD:
Allogeneic or autologous Hematopoietic Stem Cell Transplant (HSCT) patient.

I can confirm the above patient meets the inclusion criteria.

Prescriber Name:	Hospital:
Address:	Department:
City:	Country:
Phone:	Fax:
License Number:	Email:
MD Specialty:	Signature:
	Date:

8th June 2010