Spectrum Pharmaceuticals Expanded Access Request Form
Treating Physician or Medical Staff Completion ONLY
Protected Health Information must be redacted completely

Application Requirements & Instructions:

- Unless otherwise noted, all requested information is required
- Must be type-written
- English language required for all submitted information and documents
- Attach a redacted molecular report with mutation and test type
- No patient name, initials, or date of birth permitted (PHI)
- After completion, please sign, scan, and email back to eap@sppirx.com

Treating Physician Name:	**Current active, unrestricted medical licensure #:**
Institution Name:	**Institution Address (include country):**
Physician Office Phone (include country code):	**Physician Fax (include country code):**
Physician Cell Phone (include country code):	**Physician Email:**
Does the physician have experience with EGFR and/or HER2 Tyrosine Kinase Inhibitors (TKIs)?: ☐ **YES** ☐ **NO - Briefly describe experience/agents:**	
Does the physician have experience treating with investigational agents? ☐ **YES** ☐ **NO - Briefly describe experience:**	
Reason for not enrolling the patient in Poziotinib Clinical Trial (please tick the appropriate box): ☐ **No Poziotinib Clinical Trials available at a reasonably located clinical site or in the Country** ☐ **Patient is not eligible for one of the available Poziotinib Clinical Trial in the Country. Please include:** • **Reason for ineligibility:** • **Date assessed:** • **Site location of assessment:**	
Preferred Title for Single-Patient IND Protocol (USA Only):	

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Pertinent Past Medical History:	
Patient's YOB & Age:	**Patient's Gender:**
Patient's city and country of residence:	**Date of Diagnosis:**
Histologic Tumor Type:	**Anatomic sites of primary and metastatic tumor at initial diagnosis:**

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Prior therapies/regimens for NSCLC	Dose/ Frequency	# of cycles	Start Date – Stop Date (or last dose) mo/yr	Reason for discontinuation

Describe history of ILD or drug induced pneumonitis:

Please specify mutation type and provide a copy of molecular report in English (redacted):
☐ **EGFR:** ☐ **Exon 19** ☐ **Exon 20** ☐ **Exon 21**

☐ **HER2:** ☐ **Exon 19** ☐ **Exon 20** ☐ **Exon 21**

Recent Chemistry Panel results (attach or specify; ALT, AST, Alk Phos, Bilirubin, Cr..):	**Renal or Hepatic impairment?:** ☐ **YES** ☐ **NO**
Current Signs and Symptoms:	**Current ECOG Performance Status**:

Recent pertinent imaging Results:

Current site(s) of metastasis:

Pertinent comorbidities:

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Current Concomitant Medications*	Dose/ Frequency	Start Date (or date of last dose)
Include cardiac meds, anticoagulants and any anti-cancer agents that are planned to continue		
Other Key information or Notes (*optional*):		

I certify that all information in the attached is true and correct to the best of my knowledge:

Investigator Name:_____

Investigator Signature:_____

Date Signed:_____