

19



DEPARTMENT OF DEFENCE LAVARACK BARRACKS MEDICAL CENTRE

To: *The Experimental Drugs Team*
Attn: Nicki Steinberg
Therapeutic Goods Administration

Fax: (02) 6232 8112.

Tel:

Email:

From: **Dr John Simpson**
Lavarack Barracks Medical Centre
Military Post Office
TOWNSVILLE QLD 4813
Tel (07) 4771 7068
Fax (07) 4771 1674

Fax: 07 47 711674

Tel:

Email:

SUBJECT:	<i>Request for approval to prescribe tafenoquine</i>		
Reference:		Date:	<i>21 Jul 00</i>
		Pages (including cover):	2

IMPORTANT: This facsimile remains the property of the Defence Organisation and is subject to the jurisdiction of section 70 of the Crimes Act 1914. If you have received the facsimile in error, you are requested to immediately contact the sender by telephone so that arrangements can be made for the return of the document to the sender.

Instructions or comments:

Apologies for incorrectly filling in the "parent category" box on the previous forms; all are [REDACTED]

Regards,

John

19



REQUEST FOR SPECIAL ACCESS SCHEME (SAS) APPROVAL CATEGORY B and C PATIENTS ONLY

18

Commonwealth Department
Health and Family Service

- Category B:** Persons suffering from a life-threatening medical condition, even if they are not critically ill.
- Category C:** Persons suffering from a serious but not life-threatening illness.

PLEASE USE BLACK PEN, PRINT CLEARLY AND COMPLETE ALL SECTIONS

Prescribing doctor details

Name	<input type="text"/>	Hospital	<input type="text"/>
Postal address	Initial <input type="text"/> Surname <input type="text"/> Dr John Simpson Lavarack Barracks Medical Centre Military Post Office TOWNSVILLE QLD 4813 Tel (07) 4771 7058 Fax (07) 4771 1674 Postcode <input type="text"/>	Department	<input type="text"/>
		Phone number	<input type="text"/>
		Fax number	<input type="text"/>

Drug details

Active ingredient	TAFENOQUINE	Trade name	<input type="text"/>
Dose form	200mg tablet	Company/supplier	SKB
Dosage	200mg daily x 3 → 200mg weekly x 8	Route of administration	ORAL
		Duration of treatment	EIGHT WEEKS

Patient details

Patient initials	<input type="text"/>	Patient category	<input type="text"/>	Date of Birth	<input type="text"/>	Sex	<input type="text"/>
		Patient ID	<input type="text"/>	Previous SAS No.	<input type="text"/>		
Diagnosis	Recurrent vivax malaria.						

Justification for use of drug (include previous and current treatment; state whether requesting renewal of SAS approval)

Recurrent vivax malaria as per protocol from the Army Malaria Institute.

Prescribing doctor	J. Simpson	Date	21 '7' 02
Signature			

Fax to: The Experimental Drugs Team (02) 6232 8112 or Send by Mail to: The SAS Officer
TGA
PO Box 100
Woden ACT 2606