Australian Government
Department of Health and Ageing
Therapeutic Goods Administration

Please also fax approval to Ramsay pharmacy Fax 8425 3910
(or on request from doctor or patient to chosen pharmacy)

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	H pylori gastritis	Previous SAS No. (if applicable)	

Clinical justification for use of product *Include appraisal of seriousness of patient's condition; detail previous treatments and expected benefits from use of the product*	Refractory to Nexium HP7 with Peptic ulcer disease. With esomeprazole 2 x 40 mg, levofloxacin 2 x 500 mg, and amoxicillin 2 x 1 g 10 days

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	Levofloxacin	Trade name /Device name	
Company/supplier (State if imported)			
Dose form*	500mg caps	Route of administration*	po
Dosage* (dose x frequency)	i bd	Duration of treatment	10/7
Date of medical device/ biological procedure/use			

Prescribing doctor details

Name	*Initial Surname*	Hospital	
Postal address (hospital or private). The approval letter will be mailed to this address.		Department	
		Phone	
Postcode		Fax number	

Signature & date / /