

**Individual Patient Expanded Access  
Investigational New Drug Application (IND)**  
*(Title 21, Code of Federal Regulations (CFR) Part 312)*

**1. Patient's Initials**

**2. Date of Submission** (mm/dd/yyyy)

**3.a. Initial Submission**

- Select this box if this form is an initial submission for an individual patient expanded access IND, and complete only fields 4 through 8, and fields 10 and 11.

**3.b. Follow-Up Submission**

- Select this box if this form accompanies a follow-up submission to an existing individual patient expanded access IND, and complete the items to the right in this section, and fields 8 through 11.

Investigational Drug Name

Physician's IND Number

**4. Clinical Information**

Indication

Brief Clinical History (*Patient's age, gender, weight, allergies, diagnosis, prior therapy, response to prior therapy, reason for request, including an explanation of why the patient lacks other therapeutic options*)

**5. Treatment Information**

Investigational Drug Name

Name of the entity that will supply the drug (*generally the manufacturer*)

FDA Review Division (*if known*)

Treatment Plan (*Including the dose, route and schedule of administration, planned duration, and monitoring procedures. Also include modifications to the treatment plan in the event of toxicity.*)

**6. Letter of Authorization (LOA), if applicable** (*generally obtained from the manufacturer of the drug*)

- I have attached the LOA. (*Attach the LOA; if electronic, use normal PDF functions for file attachments.*)

**Note:** If there is no LOA, consult the Form Instructions.

**7. Physician's Qualification Statement** (Including medical school attended, year of graduation, medical specialty, state medical license number, current employment, and job title. Alternatively, attach the first few pages of physician's curriculum vitae (CV), provided they contain this information. If attaching the CV electronically, use normal PDF functions for file attachments.)

**8. Physician Name, Address, and Contact Information**

Physician Name (Sponsor)		Email Address of Physician
Address 1 (Street address, No P.O. boxes)		
Address 2 (Apartment, suite, unit, building, floor, etc.)		Telephone Number of Physician
City	State	Facsimile (FAX) Number of Physician
ZIP Code		Physician's IND number, if known

**9. Contents of Submission**

This submission contains the following materials, which are attached to this form (select all that apply). If none of the following apply to the follow-up communications, use Form FDA 1571 for your submission.

- |   |  |
|---|--|
| <input type="checkbox"/> Initial Written IND Safety Report                    | <input type="checkbox"/> Change in Treatment Plan                |
| <input type="checkbox"/> Follow-up to a Written IND Safety Report             | <input type="checkbox"/> General Correspondence                  |
| <input type="checkbox"/> Annual Report  | <input type="checkbox"/> Response to FDA Request for Information |
| <input type="checkbox"/> Summary of Expanded Access Use (treatment completed) | <input type="checkbox"/> Response to Clinical Hold               |

**10. Request for Authorization to Use Form FDA 3926**

- I request authorization to submit this Form FDA 3926 to comply with FDA's requirements for an individual patient expanded access IND.

**11. Certification Statement:** I will not begin treatment until 30 days after FDA's receipt of a completed application and all required materials unless I receive earlier notification from FDA that treatment may begin. I also agree not to begin or continue clinical investigations covered by the IND if those studies are placed on clinical hold. I also certify that I will obtain informed consent, consistent with Federal requirements, and that an Institutional Review Board (IRB) that complies with the Federal IRB requirements will be responsible for initial and continuing review and approval of this treatment use. I understand that in the case of an emergency request, treatment may begin without prior IRB approval, provided the IRB is notified of the emergency treatment within 5 working days of treatment. I agree to conduct the investigation in accordance with all other applicable regulatory requirements.

**WARNING: A willfully false statement is a criminal offense (U.S.C. Title 18, Sec. 1001).**

Signature of Physician	Date
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For FDA Use Only		
Date of FDA Receipt	Is this an emergency individual patient IND? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this indication for a rare disease (prevalence < 200,000 in the U.S.)? <input type="checkbox"/> Yes <input type="checkbox"/> No
IND Number		

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This section applies only to requirements of the Paperwork Reduction Act of 1995.

**\*DO NOT SEND YOUR COMPLETED FORM TO THE PRA STAFF EMAIL ADDRESS BELOW.\***

The burden time for this collection of information is estimated to average 45 minutes per response, including the time to review instructions, search existing data sources, gather and maintain the data needed and complete and review the collection of information. Send comments regarding this burden estimate or any other aspect of this information collection, including suggestions for reducing this burden, to:

Department of Health and Human Services  
Food and Drug Administration  
Office of Chief Information Officer  
Paperwork Reduction Act (PRA) Staff  
*PRAStaff@fda.hhs.gov*

*“An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB number.”*