



Campath Distribution Program
Phone: 1-877-422-6728
Fax: 1-800-513-1824
Hours: Monday – Friday, 9:00 am to 8:00 pm ET

Campath® Distribution Program – Transplant Institution Replenishment Form

Date: _____

Institution Name: _____

Institution Shipping Address: _____

The following information is needed to authorize the next shipment:


| | |
|---|-------------------|
| Number of Campath 30mg vials used in Solid Organ Transplants since your last shipment was received (should equal the number of documented vials below or attached and will equal number of replenishment vials to be shipped) | Total # of vials: |
| Number of Campath 30mg vials currently in inventory | Total # of vials: |

Either complete the below infusion log or attach a similar log/report when submitting this form:

| Institution Patient ID | Diagnosis Code | SOT Procedure Code | Date of Admin. | Lot # | # of Vials | Initials/Signature [of person(s) documenting each use] |
|------------------------|----------------|--------------------|----------------|-------|------------|--|
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I certify that the information submitted on and with this form is accurate and complete to the best of my knowledge

Authorized Institution Representative Signature Printed Name Title Date


 If you have any questions about this form or medication, please contact:
 Campath Distribution Program
 877.422.6728
 Monday through Friday, 9:00 AM to 8:00 PM EST.
Please fax completed form to 800.513.1824