**Pharmacy Form**

**Appendix 4.2.2- Pharmacy Authorization Form**

Date: DD-MMM-YYYY

Was consent obtained for pharmacy authorization? O Yes O No

**Appendix 4.2.3- Pharmacy Form**

Date of visit: DD-MMM-YYYY

|  |  |
| --- | --- |
| Is participant currently taking any concomitant medication? | O YesO No |
| If yes, any contraindication to the study drug? | O Yes, patient is not eligibleO No, patient is eligible |