Favipiravir Tablets 200 mg

Informed consent
(For Emergency Use)
To Whomsoever It May Concern

I,_____Age____,Sex_____R/o_____

_____

hereby give my express consent for receiving Favipiravir tablets 200 mg, Manufactured by Optimus Pharma Private Limited Plot No. 73/B, 73/B/2, EPIP, Pashamylaram (Village),Patancheru (Mandal),Sangareddy (District), Hyderabad-502307, Telangana, India Phone no.: +91-8455-223653, FAX: +91-40-27174641, for treatment of Mild to Moderate Covid-19.

My Doctor's Name: _____Qualification: _____, Name of the Hospital : _____ has explained to me in the language (English or Regional language) I understand that Favipiravir tablets 200 mg approval has been granted as part of the accelerated approval process considering the emergency situation and unmet medical need in light of Covid-19 outbreak in India for restricted emergency use by Government (office of DCGI, Ministry of Health and Family Welfare, Govt. of India New Delhi) in the current pandemic situation of Covid-19.

I have also been explained about the possible benefits as well as risks (including the side effects) from the usage of this drug by my treating physician, after which I have made an informed choice to take this Favipiravir tablets 200 mg willingly and under no undue pressure.

I also confirm that I have had a chance to read or be explained the contents of the Product Information leaflet / sheet that carries all the information on the usage, indication, possible adverse effects and contraindications for Favipiravir tablets 200 mg.

I understand that if I have questions, concerns, or complaints, or think the treatment has in any way hurt me, I am at liberty to withdraw the consent for my treatment with Favipiravir tablets 200 mg without giving any reason whatsoever and /or can talk to my doctor. I agree to the fact that the data being generated out of my usage of this Favipiravir tablets 200 mg may be used by Optimus Pharma for Scientific purpose/s only.

Physician's signature & Seal of the Hospital_____

Name of the Person providing consent _____

Date: _____

_____
Signature of person providing consent
(Patient, Legally authorized representative, parent, or guardian)
Date: _____

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