###### Plasma Protein and Related Products (PPRP) for Research Request Form

As part of its mandate, Canadian Blood Services distributes plasma protein and related products (PPRP) to Canadian hospitals for patient use. While meeting patient needs is Canadian Blood Services’ top priority, in some cases investigators may request small quantities of PPRP to support discovery or clinical research that will ultimately benefit Canadian patients. Please note Canadian Blood Services cannot provide researchers with any PPRP that are not part of its formulary for hospital customers and reserves the right to refuse any request due to actual or potential pressure on its inventory.

**Instructions**

Please complete the requestform **below. In addition, please send a copy of your** research protocol **and** proof of approval **by a Research Ethics Board (if applicable).**

Projects involving biohazards governed by the Human Pathogens and Toxins Act and licensed by the Public Health Agency of Canada require an approval from an Institutional Biosafety Committee or equivalent. Projects involving animal research require approval from a Canadian Council on Animal Care accredited Animal Care Committee, while those involving humans require approval from a Research Ethics Board subject to The Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans.

Canadian Blood Services will review your request once all three documents have been forwarded to [PPRPFormularyProgram@blood.ca](mailto:PPPFormularyProgram@blood.ca).

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| Study Principal Investigator | Name:  Title/Organization:  Email: | |
| Study Title |  | |
| Short Description (2-3 sentences) |  | |
| If not explained in your study protocol, how will the requested PPRP be used in your study? |  | |
| Does the study involve human subjects? | □ Yes □ No | |
| Study Start & End Dates |  | |
| Plasma Product(s) Required  (MM # and description) |  | |
| 1. Dosing Regimen 2. Number of Anticipated Patients 3. Total Volume Required (and short justification for volume required if patients are not involved) | A x B = C | |
| Contact Person Name & Email |  | |
| Phone and Fax # |  | |
| Shipping Address |  | |
| Billing Address |  | |
| Requestor Signature & Date |  |  |
| Ethics Board Authorization | Letter of approval and protocol/application attached:  □ Yes □ No  If no, rationale: | |
| **For CBS Use Only** | | |
| Approved □  Rejected □ | Rationale: | |
| Price of Product |  | |
| Total Amount Billed to Customer |  | |
| Supply Chain Operations  Approver/date |  |  |
| PPRP Formulary  Approver/date: |  |  |