

# Application information for prednisolone sodium phosphate oral liquid

With the withdrawal of the GSK brand of betamethasone (Betnesol) 0.5mg dispersable tablet from the market, an alternative oral corticosteroid is available from Aventis for patients over 12 years of age, prednisolone sodium phosphate (Redipred) oral liquid, 5mg per ml, 30ml. As this product does not have an indication for use as a mouthwash for oropharyngeal lesions it cannot be funded through the Pharmaceutical Schedule, it is therefore only available pursuant to Section 29 of the Medicines Act for patients where there is no suitable alternative.

The purpose of the Exceptional Circumstance scheme is to provide fully funded pharmaceuticals for some individuals whose needs are not met under the Pharmaceutical Schedule. Admittance to this scheme entails meeting strict criteria.

However, the Exceptional Circumstance scheme will administer the funding of Redipred for a small number of patients with certain disorders affecting the oral mucosa, that need to be treated with an oral corticosteroid. Applications are to be made by a relevant specialist.

Approvals will be granted for a fixed period, generally one year.

## CONTACT

Exceptional Circumstances  
Panel Co-ordinator  
PHARMAC  
PO Box 10-254  
Wellington

Phone: 04-916-7553  
Fax: 09-523-6870  
Email: [ecpanel@pharmac.govt.nz](mailto:ecpanel@pharmac.govt.nz)

# Application form for prednisolone sodium phosphate oral liquid

Return completed to:      Exceptional Circumstances      Phone:      04-916-7553  
    PHARMAC      Fax:      09-523-6870  
    PO Box 10-254      Email: ecpanel@pharmac.govt.nz  
    Wellington

Prior to completing this application please read the attached notes on criteria for approval. Type the application or write clearly.

Patient Details	Details of Applying Practitioner
Last Name: _____	Last Name: _____
First Name: _____	First Name: _____
Address: _____	Address: _____
Gender: Male/Female _____	Phone: _____
Date of Birth: _____	Facsimile: _____ NZMC#: _____
NHI No: _____	Email: _____
Phone No: _____	Are you a GP <input type="checkbox"/> or Specialist <input type="checkbox"/> ?

**Medicine/treatment sought:**

Chemical Name: prednisolone sodium phosphate

**Cost:**

Cost will be reimbursed at Subsidy price: \$9.95 per 30ml

1. **Dosage to be used:** \_\_\_\_\_

2. **Nominated Pharmacy:** (approval can only be granted if this is supplied.)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

3. **Entry Criteria:**

List indication for which funding for prednisolone sodium phosphate is sought:

Indication

4. **Consent:**

Patient consent has been obtained for the use of a medication for a non-registered indication.

Please indicate that patient has been consulted.

**Signature of Medical Practitioner:** \_\_\_\_\_

**Date of Request:** \_\_\_\_\_