

Application information for propylthiouracil

With the withdrawal of the Abbott brand of propylthiouracil from the market, an alternative source of propylthiouracil is available from Health Support Limited (HSL). As this product is unregistered in New Zealand it is 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 the generic propylthiouracil for a small group of people who have trialed and are unable to tolerate the funded alternative carbimazole, or for patients for whom this medication is contraindicated.

Exceptional Circumstances funding will not generally be available for patients who do not meet either of the above criteria.

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

Application form for propylthiouracil

Return completed to: Exceptional Circumstances
 PHARMAC
 PO Box 10-254
 Wellington

Phone: 04-916-7553
 Fax: 09-523-6870
 Email: ecpanel@pharmac.govt.nz

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: propylthiouracil

Cost:

Cost will be reimbursed at Cost Brand and Source

1. **Dosage to be used:** _____

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

Name: _____

Address: _____

3. **Entry Criteria:**

List treatment trialed and patient response to treatment. Where treatment has not been trialed but is contraindicated provide documentation of the reason for contraindication.

Treatment	Response/Contraindicated due to...
carbimazole	

4. **Consent:**

Patient consent has been obtained for the use of a non-registered medicine being obtained under Section 29.

Please indicate that patient has been consulted.

Signature of Medical Practitioner: _____

Date of Request: _____