

Application Form for Cancer Exceptional Circumstances Approval

Return completed form to:	Cancer Exceptional Circumstances Co-ordinator PHARMAC PO Box 10-254 Wellington	Phone Fax: Email:	04-916-7521 09-523-6870 ecpanel@pharmac.govt.nz (note: fax number redirects to Wgtn office)
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Eligibility under Cancer Exceptional Circumstances Policy

<p>A: Are you applying for approval to fund from a hospital budget, a pharmaceutical for the treatment of cancer that is not listed as a Pharmaceutical Cancer Treatment in either Part V of Section H, or Section B of the Pharmaceutical Schedule?</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p>B: Has the proposed treatment been evaluated and approved using established DHB review mechanisms involving experienced clinicians?</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p>C: Do you consider the situation for the proposed use to be unusual?</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p>D: Is the total cost of this treatment less than \$30,000?</p> <p>Note that applications in excess of \$30,000 will be sent for a cost utility analysis and decision by PHARMAC (usual timeline 2-4 weeks).</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p>E: Has the DHB hospital that will be providing treatment agreed to provide funding?</p> <p>Please attach evidence if the DHB hospital is other than that at which the applying specialist works.</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p><i>If the answer to all of the above is yes, the proposed use may be eligible under the Cancer Exceptional Circumstances policy. Alternatively, the CEC or HEC policy should be used.</i></p>		
<p>F: Is the proposed use under consideration by PHARMAC for funding, or has PHARMAC declined such use previously?</p> <p>(note a list of active applications for funding is available on PHARMAC's website http://www.pharmac.govt.nz/pdf/090205.pdf – PHARMAC staff can assist in answering this question)</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/> Don't know <input type="checkbox"/>

General Application Details

Please complete ALL relevant details. Please type or print 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: -----	

Disease/Condition	Medicine/treatment sought:
Attach further information if appropriate, a clinical report is useful.	Complete fully, and attach additional information as necessary. To cover all strengths required.
-----	Brand Name: -----
-----	Chemical Name: -----
-----	Manufacturer: -----
-----	Form and Strength: -----
-----	Cost per unit: -----
-----	Dosage to be used: -----
-----	Expected duration of treatment: -----
-----	Expected date of treatment initiation: -----
-----	Cost of treatment: -----

Frequency of condition or combination of clinical circumstances

Please describe why the clinical circumstances requiring the proposed use are unusual, and an estimate of how often this circumstance occurs in NZ:

Pharmacy who will be supplying this product

Nominated Pharmacy (if approval given from where will supplies be obtained? This MUST be the hospital pharmacy that will be dispensing the product for the patient.)
Hospital:
Address:
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Phone:.....Fax:.....

Other Issues

Is there any other relevant information that should be considered?

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Signature of Specialist: _____

Date of Request: _____