

Application Form for Hospital Exceptional Circumstances

Return completed form to:

**Hospital Exceptional Circumstances
PHARMAC**
PO Box 10-254, Wellington

Phone: 04-916-7521
Facsimile: 09-523-6870
Email: ecpanel@pharmac.govt.nz

Instructions:

Handwrite CLEARLY using a dark pen (electronic form available on request for typewritten applications).

- Supply all relevant information, attach any additional information.
- Include relevant references and clinical reports to support the proposed course of treatment.
- Please print off the form and fax it in to avoid transmitting patient information via email.

<p>Eligibility for Hospital EC</p> <p>Does the following apply?</p> <p>You are a vocationally-registered specialist employed in a public hospital;</p> <p>Applying for approval to fund from a hospital budget;</p> <p>An unsubsidised pharmaceutical for use in the community</p>	<div style="border: 1px solid black; width: 40px; height: 40px; margin: 0 auto;"></div> <p>Yes to all Eligible to apply for HEC</p>	<div style="border: 1px solid black; width: 40px; height: 40px; margin: 0 auto;"></div> <p>No for any Not eligible to apply for HEC</p>
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Sole criterion for Hospital Exceptional Circumstances

Demonstration that funding this pharmaceutical by the hospital for this patient for use in the community would be more cost-saving for the hospital than the reasonable alternative treatment options

Patient Details	Details of Applying Practitioner
NHI:	Last Name:
Gender:	First Name: NZMC#:
Date of Birth:	Dept:
Surname:	Hospital:
First Name/s:	
Address:	Phone:
	Fax (All responses are faxed):
	Email:
DHB:	Specialty:

The Disease/Condition	The Pharmaceutical
<i>What is the disease/condition that is to be treated?</i>	<i>What is the unsubsidised pharmaceutical that is being requested for the hospital to fund to use in the community?</i>
	Chemical Name:
	Brand Name:
	Manufacturer:
	Form and Strength:
	Dosage to be used:
	Dosage regimen (where applicable):
	Duration of treatment (maximum duration is 12 months):

4. DHB DETAILS

A: Which DHB is treating the patient?	
B: In which DHB does the patient reside?	
C: Which DHB has agreed to fund this treatment?	
D: Has the DHB agreed in writing to fund the treatment if it is approved under HEC? (Please gain agreement before applying for HEC).	
E: Which hospital pharmacy would dispense this if it is approved? (<i>Please ensure hospital pharmacy is aware of your application</i>)	

5. SPECIFIC COSTINGS

Completing the following table in addition to providing a written rationale will assist the Panel to assess this application. (Costings information may be completed by your Hospital Manager. However, the hospital specialist applicant must quantify the clinical risks and benefits

	A. Costs to the hospital of using HEC	B. Costs to the hospital of the likely alternative/s
Drug related costs Cost of the treatment for its duration or 1 year		
Other Costs These may include other financial and/ or non-financial costs associated with the treatment for its duration or 1 year. The Panel will assume a cost per day of \$500 for in-hospital care unless information is provided outlining greater costs.		
Clinical Risks and Benefits What is the likelihood (estimate) that the patient will benefit (describe) with this treatment over the alternative? What is the likelihood (estimate) that the patient will suffer adverse events, hospitalisations or decreased health status if this treatment not provided in the community?		
Total Cost to Hospital	A \$	B \$

Net financial impact on hospital of using HEC (A – B) \$ _____

