Application Form for RENEWAL of Cancer Exceptional Circumstances Approval

Return completed form to:	Co-ordinator	Phone	04-916-7553
		Fax:	09-523-6870
	PHARMAC PO Box 10-254 Wellington	Email:	ecpanel@pharmac.govt.nz (note: fax number redirects to Wgtn office)

1. ELIGIBILITY UNDER CANCER EXCEPTIONAL CIRCUMSTANCES POLICY

In making this RENEWAL application please confirm that the criteria under which the Initial, or previous Renewal, application was applied for are still met, as follows:

A: Are you applying for approval to fund a pharmaceutical for the treatment of cancer that is not listed as a Pharmaceutical Cancer Treatment in Section B of the Pharmaceutical Schedule?	Yes ❑ No ❑
B: Has the proposed treatment been evaluated and approved using established DHB review mechanisms involving experienced clinicians?	Yes ❑ No ❑
C: Do you consider the situation for the proposed use to be unusual?	Yes ❑ No ❑
D: Is the total cost of this treatment less than $30,000? Note that applications in excess of $30,000 may be sent for a cost utility analysis and decision by PHARMAC (usual timeline 2-4 weeks).	Yes ❑ No ❑

2. GENERAL INFORMATION

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 **Attach** further information if appropriate, a clinical report is useful.	**Medicine/treatment sought:** 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: (mg/kg/day if applicable)
	Expected duration of treatment:
	Expected date of treatment initiation:
	Cost of treatment:

PHARMACY (Note that if this is not completed the assumption will be made that the previously approved pharmacy will be dispensing supplies)

Nominated Pharmacy (This MUST be the hospital pharmacy that will be dispensing the product for the patient.)
Hospital: ……………………………………………………………………………………………
Address: …………………………………………………………………………………………
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Phone:……………………………………Fax:……………………………………………………

3. RATIONALE FOR RENEWAL OF CANCER EXCEPTIONAL CIRCUMSTANCES

1. a **full report** including details of the patient's clinical progress, the continuing need for the medication and the short and long term future management of this patient.
2. append any relevant and **recent specialist review.**
3. append any **relevant investigations** eg laboratory tests, radiology.
4. Ensure that any conditions specified in the Initial (or previous Renewal) approval are addressed in your response.

Information which is attached to this application*:*

1.
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3.
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6.
7.

4. ADDITIONAL INFORMATION Is there any other relevant information that should be considered?

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SIGNATURE

Signature of Specialist: ____

Date of Request: ____