PHARMAC
Pharmaceutical Management Agency

New Zealand Government

Application Form for RENEWAL of Hospital Exceptional Circumstances

Return completed form to:

Fax: 09 523 6870 (preferred)

Panel Co-ordinator
PO Box 10-254, Wellington
Phone: 04-916-7553
Email: ecpanel@pharmac.govt.nz

Please refer to the information sheet if necessary. Complete ALL relevant details. Please type or print CLEARLY.

Eligibility for Hospital EC Renewal **Does the following apply?**		
• You are a vocationally-registered specialist employed in a public hospital; • Applying for approval to fund from a hospital budget; • An unsubsidised pharmaceutical for use in the community • This patient has been previously approved under HEC for the requested treatment (prior to 1 March 2012), and this application is for continued treatment	**Yes to all** Eligible to apply for RENEWAL of HEC	**No for any** Not eligible to apply for RENEWAL of HEC

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. This form is to be used only for Renewals of HEC applications approvals that were granted prior to 1 March 2012.

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:
	Email:
DHB:	Specialty:

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

* Please note that any increase in dose beyond the approved amount requires PHARMAC approval prior to dispensing

1. RATIONALE FOR RENEWAL OF HOSPITAL EXCEPTIONAL CIRCUMSTANCES

Rationale for continued course of treatment:

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(Please continue on page 4 if there is more information than the space provided here.)

2. HOSPITAL ADMISSION HISTORY

Please detail any admissions since the Initial or most recent HEC approval, and/or attach the discharge summary.

Date Admitted	Date Discharged	Reason for Admission

(Please continue this list on page 4 if there is more information than the space provided here.)

3. DHB DETAILS - Please complete if there have been any changes from the Initial application

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? *(Please ensure hospital pharmacy is aware of your application)*	

4. SPECIFIC COSTINGS- Please complete if there have been any changes from the Initial application, particularly where there have been dosage changes.

Completing the following table in addition to providing a written rationale will assist in assessing 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 renewing 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 has been the benefit (describe) that the patient has obtained 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) $_____

6. ATTACHMENTS

Please attach any additional information which may help in assessing this application. This may include recent clinic letters, lab results, hospital admission records, management plan, and any other information which may be relevant.

Additional information which is attached to this application*:*

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3.
4.
5.

(Please continue this list below if there is more information than the space provided here.)

7. ADDITIONAL INFORMATION

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Signature of Medical Practitioner: _____

Date of Request: _____