PHARMAC
TE PĀTAKA WHAIORANGA

Contact details:
Phone: 0800 66 00 50 option 2
Email: nppa@pharmac.govt.nz

Exceptional Circumstances application for funding of an alternative brand of intravenous trastuzumab (Herceptin)

Return completed form to:
Exceptional Circumstances
PHARMAC
PO Box 10-254
WELLINGTON
Phone: 0800 023 588, option 2
Email: NPPA@pharmac.govt.nz

Pharmac will consider a named patient funding application for a return to the Herceptin brand of intravenous trastuzumab. This is for people who experience an adverse reaction reasonably attributable to an excipient in the funded brand following a transition from Pharmac funded treatment with Herceptin brand to the Pharmac funded Herzuma brand of trastuzumab.

Duration of funding for the Herceptin brand for an individual will, if granted, be determined by Pharmac. This will either be:

- to allow a person to complete their planned treatment course for early breast cancer; or
- until a person with metastatic breast cancer experiences disease progression

Pharmac has secured a small quantity of Herceptin stock. While we anticipate supply of the Herceptin brand will continue for those who need it, we are unable to ensure this will occur indefinitely.

Please note: this form should be completed electronically and should not be handwritten.

Patient and Applicant Details

Patient Details	**Details of Applying Practitioner**
Last name:	Last name:
First Name:	First name
Gender:	Address:
Date of Birth:	
NHI No:	
	Phone
	NZMC#:
	Email address:

Early Breast Cancer

Please provide the following information to support consideration of this request:

Patient's disease has not progressed while receiving intravenous trastuzumab treatment	☐
Patient has not completed their planned treatment course with intravenous trastuzumab for early breast cancer	☐
Patient has attempted a transition from funded Herceptin to funded Herzuma	☐
Patient has experienced an adverse reaction which is reasonably attributable to the difference in excipients between the two brands	☐

Additional information to support consideration of this request (please include relevant clinic letters and notes as applicable to describe timing, severity, prior treatment and mitigations):

Medicine and Dosage details:

Form: Injection for infusion	
Patient weight:	
Dosage required:	
Duration of remaining treatment course:	

Nominated hospital pharmacy

Where will supplies be required, if approval of this treatment is granted? (This will be a hospital pharmacy):

Name:	
Te Whatu Ora Hospital:	
Address:	
Phone:	

Declaration

By submitting this form

- I confirm that all information provided is correct to the best of my knowledge.
- I agree to provide Pharmac, or its agent, all additional information they reasonably request.
- I acknowledge that I am responsible for obtaining any patient consent required for that additional information.

Signature of Medical Practitioner: _____

Date of Request: _____

Metastatic Breast Cancer

Please provide the following information to support consideration of this request:

Patient's disease has not progressed while receiving intravenous trastuzumab treatment	☐
Patient has attempted a transition from funded Herceptin to funded Herzuma	☐
Patient has experienced an adverse reaction which is reasonably attributable to the difference in excipients between the two brands	☐
Additional information to support consideration of this request (please include relevant clinic letters and notes as applicable please include relevant clinic letters and notes as applicable to describe timing, severity, prior treatment and mitigations):	

Medicine and Dosage details:

Form: Injection for infusion
Patient weight:
Dosage required:
Duration of remaining treatment course:

Nominated hospital pharmacy

Where will supplies be required, if approval of this treatment is granted? (This will be a hospital pharmacy):

Name:	
Te Whatu Ora Hospital:	
Address:	
Phone:	

Declaration

By submitting this form

- I confirm that all information provided is correct to the best of my knowledge.
- I agree to provide Pharmac, or its agent, all additional information they reasonably request.
- I acknowledge that I am responsible for obtaining any patient consent required for that additional information.

Signature of Medical Practitioner: _____

Date of Request: _____