PHARMAC
TE PĀTAKA WHAIORANGA

Exceptional Circumstances application for funding of an alternative brand of diabetes technology

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 an alternative:

- insulin pump and insulin pump consumables; and/or
- continuous glucose monitor (CGM)

This is for people who are not able to use the funded options listed in the Pharmaceutical Schedule for clinical reasons.

Duration of funding for the continuous glucose monitor, insulin pump and insulin pump consumables for an individual will, if granted, be determined by Pharmac.

Please note,

- *applications for continuous glucose monitors and insulin pumps, and consumables can be considered from 1 October 2024*
- *Applications should be made by the relevant treating clinician.*

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:	

Insulin pump and insulin pump consumables

Please provide the following information to support consideration of the request for an insulin pump and insulin pump consumables only:

Both:		
	The individual meets the eligibility criteria for access to the listed insulin pumps and insulin pump consumables	☐
	And any of the following:	
	The individual lives with a significant cognitive impairment or physical disability which would make it difficult to learn how to use the listed insulin pumps and insulin pump consumables. *(Note, this would be considered in situations where the individual does not have a support person who would be able to facilitate a change to a listed insulin pump and insulin pump consumables).*	☐
	The individual has extremely difficult social circumstances which render the listed insulin pumps and insulin pump consumables inadequate to meet their clinical needs.	☐
	Due to the individual's clinical circumstances, the listed insulin pumps and insulin pump consumables are not clinically appropriate in the opinion of the treating clinician.	☐
Additional information to support consideration of this request (please include relevant clinic letters and notes as applicable to describe the above):		

Pharmaceutical and quantity details:

Product: insulin pump	
Brand / model:	
Pharmacode:	
Quantity required:	

Pharmaceutical and quantity details:

Product: insulin pump consumables	
Brand / model:	
Pharmacode:	
Quantity required (insulin pump consumables per 3 months):	

Nominated pharmacy

Where will supplies be required, if approval is granted?

Name:	
Pharmacy:	
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: _____

Continuous glucose monitor, insulin pump and insulin pump consumables to create an automated insulin delivery system

Please provide the following information to support consideration of the request for an insulin pump, insulin pump consumables and compatible continuous glucose monitor:

Both:		
	The individual meets the eligibility criteria for access to the listed continuous glucose monitors, insulin pumps and insulin pump consumables	☐
	And any of the following:	
	The individual lives with a significant cognitive impairment or physical disability which would make it difficult to learn a new system. *(Note, this would be considered in situations where the individual does not have a support person who would be able to facilitate a change to a listed insulin pump and insulin pump consumables.)*	☐
	The individual has difficult social circumstances which render the listed automated insulin delivery systems inadequate to meet their clinical needs.	☐
	Due to the individual's clinical circumstances the listed insulin pumps and insulin pump consumables are not clinically appropriate in the opinion of the treating clinician.	☐
Additional information is required to support consideration of this request (please include relevant clinic letters and notes as applicable to describe the above):		

Pharmaceutical and quantity details:

Product: insulin pump	
Brand / model:	
Pharmacode:	
Quantity required:	

Pharmaceutical and quantity details:

Product: insulin pump consumables	
Brand / model:	
Pharmacode:	
Quantity required (insulin pump consumables per 3 months):	

Pharmaceutical and quantity details:

Product: continuous glucose monitor	
Brand / model:	
Pharmacode:	
Quantity required (continuous glucose monitors per 3 months):	

Nominated pharmacy

Where will supplies be required, if approval is granted?

Name:	
Pharmacy:	
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: _____

Continuous glucose monitor

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

Both		
	The individual meets the eligibility criteria for access to the listed continuous glucose monitors.	☐
	Due to the individual's clinical circumstances, the listed continuous glucose monitors are not clinically appropriate in the opinion of the treating clinician.	☐
Additional information to support consideration of this request (please include relevant clinic letters and notes as applicable to describe the above):		

Pharmaceutical and quantity details:

Product: continuous glucose monitor	
Brand / model:	
Pharmacode:	
Quantity required (continuous glucose monitors per 3 months):	

Nominated pharmacy

Where will supplies be required, if approval is granted?

Name:	
Pharmacy:	
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: _____