PHARMAC
TE PĀTAKA WHAIORANGA

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

Application for funding of an alternative brand of bevacizumab for an individual patient

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 individual funding applications for an alternative brand of bevacizumab for recurrent respiratory papillomatosis for people who it would be clinically inappropriate or difficult to transition to the newly funded brand, Vegzelma.

The duration of funding for an alternative brand of bevacizumab will, if granted, will be determined by Pharmac. This will either be:

- To allow a person to complete their funded treatment course; or
- Until it would be clinically appropriate for a person to transition to the Vegzelma brand.

Pharmac cannot ensure supply of alternative brands of bevacizumab. However, this process provides funding for approved applications, where an alternative brand can be sourced.

Please complete the 'initial' form for the first application for an alternative brand of bevacizumab, and the 'continuation' form for any subsequent applications.

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:

Recurrent Respiratory Papillomatosis - initial application for an alternative brand of bevacizumab

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

Patient has recurrent respiratory papillomatosis that has been treated with funded bevacizumab accessed via HML restriction; and • Patient has not yet received the maximum funded quantity of 6 doses of bevacizumab within 12 months of initiation; and • The treatment is for intra-lesional administration.	☐
AND	
Patient has rapidly recurrent disease and it is considered clinically inappropriate to change patient to the Vegzelma biosimilar brand of bevacizumab; OR	☐
Patient has trialed the Vegzelma biosimilar brand and experienced an adverse event attributable to this brand (please provide details below).	☐
Additional information to support consideration of this request (please include relevant clinic letters and notes as applicable and describe the length of time on an alternative brand required):	

Medicine and Dosage details:

Form: Injection for intralesional administration
Brand:
Pharmacode:
Dosage required:
Duration of remaining treatment course (including number of doses):
Cost:

Nominated hospital pharmacy

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

Name:
Health NZ | 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: _____

Recurrent Respiratory Papillomatosis - continuation

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

Patient requires further treatment with bevacizumab for recurrent respiratory papillomatosis; and • It has been at least 12 months since either bevacizumab initiation or the previous continuation approval, as applicable; and • Maximum of 6 doses; and • The treatment is for intra-lesional administration; and • There has been a reduction in surgical treatments of disease regrowth as a result of treatment.	☐
It remains clinically inappropriate to change patient to the Vegzelma brand of bevacizumab.	☐
Additional information to support consideration of this request (please include relevant clinic letters and notes as applicable and describe the length of time on an alternative brand required):	

Medicine and Dosage details:

Form: Injection for intralesional administration
Brand:
Pharmacode:
Dosage required:
Duration of remaining treatment course (including number of doses):
Cost:

Nominated hospital pharmacy

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

Name:
Health NZ | Te Whatu Ora Hospital:
Address:
Phone:

Declaration

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Signature of Medical Practitioner: _____

Date of Request: _____