Information Sheet for Alpha Tocopheryl Acetate

Alpha tocopheryl acetate (Micelle E) has been delisted from the Pharmaceutical Schedule from 1 June 2011, as the supplier of this product has withdrawn from the New Zealand market.

Until such time as PHARMAC can reach an agreement to fund another brand of alpha tocopheryl acetate on the Pharmaceutical Schedule, PHARMAC will consider applications for funding of alpha tocopheryl acetate from relevant medical practitioners under certain clinical circumstances.

All patients will be expected to meet the following minimum criteria and applications will be assessed on an individual patient basis.

Criteria:

Either:

1. Cystic fibrosis patient; and
   - 1.1. Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck); or,
   - 1.2. The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contra-indicated or clinically inappropriate for the patient.

Or

2. All:
   - 2.1. Infant or child with liver disease or short gut syndrome; and
   - 2.2. Requires vitamin supplementation; and
   - 2.3. Either:
     - 2.3.1. Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplements (Vitabdeck); or,
     - 2.3.2. The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contra-indicated or clinically inappropriate for patient.

All approvals will be valid for a maximum of two years or until such time that a brand of alpha tocopheryl acetate is listed on the Pharmaceutical Schedule.

The Named Patient Pharmaceutical Assessment (NPPAPolicy provides a mechanism for individual patients to receive funding consideration for medicines not listed in the Pharmaceutical Schedule (either at all or for their clinical circumstances). However NPPA funding would not generally be available to those who do not meet the NPPA Policy pre-requisite criteria.

PHARMAC has the discretion to consider applications to fund pharmaceuticals outside of the NPPA Policy and has decided to allow patient specific applications for the funding of alpha tocopheryl acetate. An EXCP number will be generated for all approvals to enable pharmacies with community contracts to claim for the medicine dispensed. All claims will be reimbursed at the Cost Brand Source price.

To submit an application for funding of alpha tocopheryl acetate in the community for your patient, please complete the application form below.

Application Form for Alpha Tocopheryl Acetate

Return completed form to:
NPPA Co-ordinator
PO Box 10-254
Wellington
Phone: 0800 660 050 option 2
Fax: 09-523-6870
Email: nppa@pharmac.govt.nz

Patient Details

Last Name:
First Name:
Address:
Gender: Male ☐ Female ☐
Date of Birth:
NHI No:

Details of Applying Practitioner

Last Name:
First Name:
Address:
Phone:
Facsimile: NZMC#:
Email:

Application (tick boxes where appropriate)		***Yes***	***No***
Does this patient have Cystic Fibrosis?		☐	☐
Is this patient an infant or a child with liver disease or short gut syndrome?		☐	☐
Does this patient require vitamin supplementation?		☐	☐
Either	Has this patient tried and failed the other available funded fat soluble vitamin (A,D,E,K) supplement (Vitabdeck)?	☐	☐ *
Or	Is the funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) contra-indicated or clinically inappropriate for the patient?	☐ *	☐
Is this patient currently on this treatment?		☐	☐

*Please include the reasons why the patient cannot be treated with the funded fat soluble vitamin A,D,E,K supplement. What is your rationale for this patient being on this treatment?

Further space is available on the following page if required.

Medicine details:

Chemical Name: alpha tocopheryl acetate
Brand Name:
Manufacturer:
Form & Strength:
Pharmacode:

Dosage required

Please detail the maximum daily dosage of alpha tocopheryl acetate your patient will require within the next 2 years e.g. "up to 1mL daily"

Dosage:

Nominated pharmacy

Where will supplies be obtained if approval of this treatment is granted? (This will generally NOT be a hospital pharmacy):

Name:
Address:
Phone

Any additional information:

Signature of Medical Practitioner: _____

Date of Request: _____