PHARMAC
Pharmaceutical Management Agency

New Zealand Government

Application Form for RENEWAL of Community Exceptional Circumstances Approval

Return completed form to:
Panel Co-ordinator
PHARMAC
PO Box 10-254, Wellington
Phone: 04-916-7553
Fax: 09-523-6870
Email: ecpanel@pharmac.govt.nz

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

This form should only be used for applying for RENEWAL of Community Exceptional Circumstances approvals that were granted prior to 1 March 2012.

1. GENERAL INFORMATION

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 *What is the disease/condition that is to be treated?*	Pharmaceutical *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:

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

Nominated Pharmacy (A community pharmacy from where the patient can collect supplies should this request be approved. Note that if this is not completed the assumption will be made that the previously approved pharmacy will be dispensing supplies)

Name:
Address:
Phone:

2. COST ESTIMATE

(Please provide an updated cost estimate especially if there has been a change in dosage from the Initial approval). Please note that an increase in dose of an Exceptional Circumstances medication beyond the approved dosage must have approval from PHARMAC prior to dispensing.

Cost per year (quoted by nominated pharmacy, based on dosage requested. Cost must be COST BRAND SOURCE without mark-ups or dispensing fees)	$
Anticipated duration of requested treatment:	

3. RENEWAL INFORMATION

1. a **full report** including details of the patient's clinical progress, the continuing need for the medication and the short and long term future management of this patient.
2. append any relevant and **recent specialist review.**
3. append any **relevant investigations** eg laboratory tests, radiology.
4. Ensure that any conditions specified in the Initial (or previous Renewal) approval are addressed in your response.

Additional information which is attached to this application*:*

1.
2.
3.
4.
5.
6.
7.

4. SIGNATURE

Signature of Medical Practitioner: ______________________________________

Date of Request: ____