Request for Supply of Non-PBS Pharmaceutical or Medical Supplies - Individual Patient Approval Form

This form is to be used for supply of medication in one of the following circumstances

- ☐ Inpatient access to a non-formulary drug for one patient only.
- ☐ Inpatient access to a formulary drug for a non-formulary indication
- ☐ Subsidised Outpatient access to a formulary drug

Applicant Details

	Name	**Email address**
Local prescriber		
Specialist / advising consultant (if relevant and if not local prescriber)		

Patient Name, URMN and Date of Birth

Medication Details **(seek assistance from pharmacy if not sure regarding cost or TGA details)**

Approved (Generic) Name		**Dosage form**	
Strength		**Dose**	
Planned duration		**Unit cost**	
Indication			
Is this a TGA licenced indication for this medication?	**YES** ☐ **No** ☐ **NB. If "no", evidence of efficacy for the indication is required before approval can be progressed. Please list / attach articles supporting use for the indication.**		

Patient History

Relevant past medical history	
Previous treatments that the patient has received for this condition to date if applicable	
Treatment :	Response :
Treatment :	Response :
Treatment :	Response :

High Cost Medication Endorsement required if > $10 000 (see policy and delegation schedule) **Name:** **Position:** **Signature / He:** **Date:**

Outcome Measures / Stopping Criteria (High Cost drugs only)

Anticipated outcome at end of treatment (e.g cure / remission etc)	
Criteria for cessation of medicine (e.g. non response, adverse effects, end of treatment)	

Outpatient Supply

Is the medication listed on the PBS for this indication?	**YES ☐ NO ☐**
If this medication is available on the PBS why is supply via the hospital pharmacy being requested?	
Is the medication being requested under the Special Access Scheme (SAS)?	**NO ☐** **YES – supply SAS approval**

Confidential- Declaration of potential conflict of interest
Please identify if you have any actual or potential conflicts of interest

I declare a potential conflict of interest yes ☐ no ☐

Examples of potential conflict include:	Please provide a brief description of any potential conflict for consideration.
□ Paid positions including invited lectures and membership of advisory panels etc for which honoraria or considerations in kind were received □ Shares and commercial dealing □ Financial or other sponsorship of research □ Subsidy of travel, accommodation or entertainment □ Gifts of any kind	

Form completed by:	**Supported by:** *(Head of Department or DMS or equivalent)*
Name: Signature / HE : Date: Role description: Name of Snr Doctor with governance for patient (if not applicant): Preferred contact details for applicant:	1. Name: Signature: Date: **All IPAs must have a HOD / DMS / RMD Signature to be accepted for review at DTC / MSG**

DTC / MSG USE ONLY **Date request received:**	**Overall Cost:** Unit cost: $ Est Monthly Cost $	**Request:** **Approved** ☐ **Not Approved** ☐ **Pending** ☐ Signed: _____ Chairman / Secretary / DTC/MSG Date:
Applicant notified? Name: **Date:**	Verbal ☐ Email ☐	

Where appropriate, this form is to be completed in consultation with the Outpatient Supply of Non-PBS Medications Policy.