Queensland Government

Date of Request:

For use in all Queensland Public Hospitals

INDIVIDUAL PATIENT REQUEST
for approval of a non-LAM medicine or indication

Hospital :

(Affix Patient identification label here)

URN: Date of Birth

Family Name:: Male ☐

Given Name: Female ☐

This request is for: New Approval ☐ Renewal of Existing approval: ☐ Weight (kg):

1. DETAILS OF MEDICINE

Drug Name/Form/Dose and Frequency

Proposed Indication for use and place in therapy :

Proposed duration of therapy:

Registration status: please answer one of the following

This medicine is not registered in Australia. I will complete and submit the necessary TGA approval forms and obtain patient consent *(Forms available from TGA website: http://www.tga.gov.au/hp/sas.htm#forms)* ☐

OR

This medicine is registered in Australia ,

- ☐ for this indication, but the MEDICINE is not listed on the LAM
- ☐ for this indication, but the INDICATION is not listed on the LAM
- ☐ but not for this indication (patient consent is required)
- ☐ and is being offered as a patient familiarisation program

Will the patient be eligible for ongoing supply through the PBS/HSD programs? Yes ☐ No ☐

2. CLINICAL DETAILS/HISTORY

Clinical History, including details of co-morbidities:

Previous Medications and reason for discontinuing:

Is there any non-medication treatment (eg: Surgery) for this condition? Has it been tried? and/or why is it not suitable?

Expected outcome and how it will be measured?

Financial, clinical or life implications for this patient if not approved:

3. SUPPORTING EVIDENCE - please attach copies

Reference 1:

Type of evidence: (*Choose one)*

Reference 2:

Type of evidence: *(Choose One)*

If this treatment has been recommended by a Clinical Expert from elsewhere, please provide details:

Are you aware of any previous requests for this medicine &/or indication to be listed on the LAM? Yes ☐ No ☐

Are you aware of any other Districts with local approval for this medicine &/or indication Yes ☐ No ☐

Please provide details of where/when if approved and reasons if rejected:

Has this item been approved previously for you to prescribe to <u>other</u> patients for the same indication? Yes ☐ No ☐

If yes, state the number of patients and details of clinical outcomes

4. PHARMACOECONOMIC EVALUATION

What is the cost, based on dose and expected course of treatment? If ongoing, give monthly costs

Are there any associated costs, such as admission for administration, equipment, monitoring, or other resources?

Are there any cost savings or offsets?

What are the financial implications for the District if not approved?

For requests exceeding $500 as a single treatment or $5,000 per course or per annum, complete section 5,6,and 7:

1. **Obtain a second clinical opinion. Ideally this wil be conducted by the Director of the service, or where this is not possible, a specialist in the same field.**

2. **Forward to the Divisional business manager, for acknowledgement of the possible budgetary implications**

3. **Forward to the Executive Director of the Division**

5. DIRECTOR / PEER REVIEW

Name and position of person reviewing: _____

[ ] this application.

Comments:

6. BUSINESS MANAGER ACKNOWLEDGEMENT

Signature of Business Manager

Printed Name of Business Manager

Date:

7. EXECUTIVE DIRECTOR ACKNOWLEDGEMENT

Signature of Executive Director

Printed Name of Executive Director

Date:

8. DECLARATION BY REQUESTING PHYSICIAN

☐ *I certify that I am not aware of any potential conflicts of interest that may arise from this application OR*

☐ *I may have a conflict of interest:*

☐ *I agree to provide written feedback as requested by the Committee.*

ALSO consider if patient is from another hospital/District:

☐ If approved, I agree to immediately communicate with the pharmacy or appropriate medical officer at the home hospital and ensure arrangements are made for ongoing supply.

Signature and Contact details required below:

Signature of Requesting doctor	**Printed Name of requesting doctor**	**Contact phone or pager**

Send to Director of Pharmacy (Secretary of D&T Commitee)

Print Form

9. D&T Committee or Delegate:

Date Received: ☐ Approved ☐ Not Approved

Comments/Conditions

Signature Printed Name Date

☐ Requesting Clinican Notified by: Memo / E-mail / phone Sign and date: _____

☐ Pharmacy Notified by: this form / Email / phone Sign and date: _____

Send completed form to the Pharmacy for recording and filing.

☐ Recorded in Special Products Register: Sign and date: _____

☐ Original document scanned and saved OR filed in required place

☐ Stock availability checked and holding level changed if ongoing

Grateful acknowledgement to the Gold Coast Health Service District Medication Advisory Committee who provided this revised form and the Central Queensland Medicines Committee for their input.