AUSTRALIAN HEALTH SERVICE ALLIANCE
REQUEST FOR HIGH COST DRUGS EX GRATIA

Guidelines for completion / application

This form is to be used when requesting consideration of ex-gratia funding for very high cost drugs which are not covered under other funding arrangements such as HPPAs, EDL, or PBS.

For funding to be considered, all areas of the form must be completed in legible writing, and additional information requested below supplied - incomplete or illegible forms will be returned.

- Please forward this submission directly to the health fund concerned with as much notice as possible prior to administration as the health fund may not agree to contribute to submissions after the drug has been administered. *(Extreme Circumstances may be considered).*
- The Health Fund will endeavor to respond to the application by the requested time; this cannot however, be guaranteed - a complete submission will assist this process.
- Where multiple doses are required, the Fund may request evidence of outcomes prior to committing to on-going funding consideration.

Date Request Sent: ..... **Date Response Requested by:** .....

Hospital Details:

Hospital/Facility Name:	
Hospital Contact:	
Contact Phone Number:	
Contact Fax Number:	

Member Details:

Member/Patient Name:	
Member Date of Birth:	
Health Fund:	
Fund Membership Number:	

To be completed by Prescribing Clinician:

Name of Prescribing Clinician:	
Clinician's Phone Number:	

Principle Diagnosis:
Co-Morbidities:
Surgical Procedures Performed: *(Include date they were performed)*

Signature: _____ Date: _____

Drug Details:

Requested Drug. (Generic and Trade Name):	
Is the Drug TGA approved for this indication? ❑ YES ❑ NO	
Is this a SAS *(Special Access Scheme)* drug? ❑ YES ❑ NO	
Dose Loading (mg):	Dose On-going (mg):
Mode of administration? ❑ IV ❑ Oral ❑ IM ❑ SC	
If IV - duration of Administration?	

Number of Doses requested:
Number of doses/treatments per course:
Number of courses required:
Proposed Cost per dose (without Mark-up) *Please note: Mark-up cannot be charged*
Total cost of treatment:

On what basis will the patient be treated?
❑ Overnight ❑ Same Day ❑ Outpatient

Drug Company Support Programs:

Are there currently any trials in progress for this drug?
❑ YES ❑ NO
Does the drug company offer any support programs/compassionate funding?
❑ YES ❑ NO
If YES please provide details:
If YES, does this patient meet the criteria for this program?
❑ YES ❑ NO
Have you applied to the drug company for this patient to be included in the support/compassionate program?:
❑ YES ❑ NO

To be completed by Prescribing Clinician:

What is the standard drug treatment for the patient's condition?
Has standard drug therapy been prescribed?
❑ YES ❑ NO
If YES what was the outcome?
If NO, why not?
Are there any alternatives that are on PBS or less costly?
❑ YES ❑ NO
If YES, specify: