## Individual Patient Use (IPU) Application

# Use this form to apply for approval for hospital use of a medicine in an individual patient under the care of Canberra Hospital and Health Services.

# *Completion of this application is the responsibility of the treating specialist.*

The Drug and Therapeutics Committee will assess the application based on previous treatment failure with standard therapy, the risk associated with the proposed therapy, evidence of effectiveness and financial implications. High cost and high risk treatment options require rigorous review to ensure that the risk benefit ratio is adequately evaluated.An outpatient approved regimen will require the patient to pay a general or concessional copayment toward the cost of the medicine at the time of dispensing.

# Patient Details

|  |  |
| --- | --- |
| Patient Name: | Stephen GARRETT |
| MRN: | 20117558 |
| Date of Birth: | 17/3/1957 |
| Ward / Outpatient Location: | Outpatient |

# Standard application review time is five business days. If you require more urgent assessment of your application please contact the formulary management pharmacist on ext 42721, or email [dtc@act.gov.au](mailto:dtc@act.gov.au) to discuss an appropriate timeframe.

# Details of Medicine

|  |  |
| --- | --- |
| Australian approved (generic) name: | Somatuline Autogel |
| Dose, frequency, route: | 120mg IM, monthly |
| Proposed indication for use: | Multifocal neuroendocrine tumours |
| Proposed duration of therapy: | Ongoing |

Hospital formulary listing of the medicine: (please answer **ONE** of the following)

The medicine:

Is not listed on hospital formulary

Is listed on hospital formulary, but the proposed ***indication*** is outside hospital formulary restriction

Will the patient be eligible for ongoing supply through the Pharmaceutical Benefits Scheme?

~~YES~~/NO

If no, explain implications for continuity of supply. (For example, will the drug be supplied for inpatient use, outpatient use, or both? Will the hospital be required to provide ongoing therapy after discharge?)

|  |
| --- |
| Ongoing outpatient supply |

|  |  |
| --- | --- |
| Cost per month: |  |
| Expected annual number of patients presenting with this therapy requirement |  |

**Reasons for Application**

Detail your reasons for applying to use this medicine.

**Address the following points and provide published evidence as support (in full-text PDF format)**:

* Patient specific details; including past treatment options and response
* Alternative treatment options; including non-pharmacological options and treatment plan if DTC approval is not obtained
* Expected patient outcomes with planned objective measurements for achieving these outcomes
* Potential for adverse drug reaction and risk profile of the medicine

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**Declaration by Requesting Consultant**

By signing below, I certify that:

I agree to provide written feedback by requested due dates regarding the patient in the format requested by the Drug and Therapeutics Committee.

If the medicine is ***not*** registered for use in Australia, I will complete and submit the necessary TGA approval forms and obtain patient consent.

I am not aware of any potential conflicts of interest that may arise from this application

**OR**

I may have a conflict of interest: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Details of Requesting Consultant**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Treating Specialist: |  | | |
| Specialty: |  | | |
| Signature: |  | Date: |  |
| Contact number: |  | | |

|  |
| --- |
| **The Drug & Therapeutics Committee will determine the need for and frequency of progress reports at initial application assessment. When the Committee receives a progress report, if approved for continued therapy, the Committee will notify the applicant without requesting further endorsement from the Head of Unit, or Executive Director. The Committee agrees to forward a monthly report of approvals and expenditure for the unit. The Committee will notify the Head of Unit and Executive Director if concerns regarding ongoing approval costs are identified.** |

**Declaration by Clinical Director of Specialty**

By signing below, I certify that:

I approve the journaling of cost of treatment to the unit for the duration approved by the Drug & Therapeutics Committee.

**OR**

I approve the journaling of cost of treatment to the unit for the duration approved by the Drug & Therapeutics Committee in the initial approval. I request a copy of each progress report to approve ongoing costs.

**Endorsed by:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Clinical Director of Specialty |  | | |
| Position / Appointment |  | | |
| Signature |  | Date |  |

If cost for 12 months treatment is more than $2,000 endorsement by financial delegate (Divisional Executive Director) is required. This will be obtained via the DTC Secretariat.

*Committee Use Only*

**Financial Delegate Approval:**

**Declaration by Executive Director**

By signing below, I certify that:

I approve the journaling of cost of treatment to the unit for the duration approved by the Drug & Therapeutics Committee.

**OR**

I approve the journaling of cost of treatment to the unit for the duration approved by the Drug & Therapeutics Committee in the initial approval. I request a copy of each progress report to approve ongoing costs.

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Executive Director |  | | |
| Signature |  | Date |  |

#### Forward the completed application and associated evidence via email to the Secretary of the Drug and Therapeutics Committee [dtc@act.gov.au](mailto:dtc@act.gov.au)