NSW TAG NSW Therapeutic Advisory Group Inc. | Advancing quality use of medicines in NSW

Medicines Access Program
Prescriber Acknowledgement Form

I, _____ hereby accept responsibility for
(Print name)
prescribing the medicine _____ under the specified Medicines Access Program.
(Name of medicine)

Medicines Access Program name:	
Sponsor/Company name:	
Start date:	Stop date:

Please tick boxes below

I understand that:

- ☐ The medicine may not be subsidised by the Pharmaceutical Benefits Scheme (PBS) for my patients at the conclusion of the Medicines Access Program.
- ☐ The hospital is not expected to subsidise the cost of the medicine at the end of Medicines Access Program unless approved for use on the hospital formulary or the hospital's Drugs and Therapeutics Committee has approved non-formulary use in an individual patient.
- ☐ In the situation where the medicine is not subsidised by the end of the program, the medicine may need to be switched over to a suitable subsidised alternative. I will ensure that each patient understands this and discuss alternative treatments with them.
- ☐ Where the medicine does not have PBS listing at the conclusion of the Medicines Access Program, I will ensure that I obtain the required approval to continue prescribing the medicine for my patients. Failing that, I will switch the patient to a suitable subsidised alternative. I will organise the request for approval or the changeover to a suitable alternative in a timely manner.

Patient considerations:

- ☐ I must provide information about the medicine and the program to each patient.
- ☐ I am required to obtain patient consent prior to using this medicine under the Medicines Access Program.
- ☐ I must make patients aware that usual hospital charges will apply to medicines dispensed under the Medicines Access Program.
- ☐ I must ask patients if they are prepared and able (have the means) to pay for the above medicine if they wish to continue therapy at the conclusion of the program.
- ☐ I must make patients aware of any actual, potential or perceived conflicts of interest I have in relation to this Medicines Access Program.

Declaration of conflict of interest:

- ☐ I certify that I am not aware of any conflict of interest which may arise in respect of this Medicines Access Program

OR

- ☐ I may have a conflict of interest for the following reason/s: _____

_____

Prescriber's Signature:	Date:
Prescribers Name (please print):	
If signing on behalf of a consultant, please write the consultant's name please print):	

NSW Therapeutic Advisory Group acknowledges the work of the Western Australian Therapeutics Advisory Group in the development of this document.