

Formulary Amendment Form: Section 100 (S100) Medicine Addition

A. Introduction

Use this form to apply for:

- **Addition of a new drug, which is approved for reimbursement under Section 100, to the Formulary.**

For approval to use this drug on an individual patient basis for non-S100 indications, use the [IPU application form](#)

For amendments to existing Formulary drugs, use the relevant customised [Formulary form](#)

For all other Formulary requests, use the [Formulary Submission form](#)

Complete Sections B-H.

B. Product Profile

Active Ingredient Name(s)	
Trade / Brand Name	
Formulation(s) – provide full details	
Manufacturer/Supplier	
Pharmacological class and action (summary)	

C. Indication(s) for use

(This drug will only be considered for approval on the formulary for the indications listed for reimbursement under Section 100. For approval for non-S100 indications, please complete a full Formulary submission)

List the S100 indications (or attach a copy of the relevant section of the PBS Schedule).

D. Financial Implications

- i. **List any cost implications for the hospital e.g. likelihood of having to provide inpatient supply, additional monitoring requirements.**

- ii. **Will this drug replace any existing Formulary drug? Please supply details.**

- iii. **How many patients per year do you estimate will be treated with this drug in this hospital/district?**

E. Safety Implications

i. List any safety implications, e.g. drug interactions, poor packaging

ii. Does a guideline/protocol need to be developed to assist prescribing and/or administration?

Yes, please provide details below No

iii. Is training for prescribers or nurses needed to ensure safe and/or effective use of this medicine?

Yes, please provide details below No

F. Conflicts of Interest

Financial or other interests resulting from contact with pharmaceutical companies, which may have a bearing on this submission:

- Gifts
- Travel expenses
- Samples
- Industry paid food/refreshments
- Honoraria
- Research support
- Nil conflict of interest
- Other support (describe below)

G. Approval process

The following must be completed prior to submitting application to the DTC

Details of Applicant making the request

Name of Applicant			
Position / Appointment			
Signature		Date	
E-mail address for correspondence			
Phone number			

Endorsed by

(Must be completed by Head of Unit/Manager of Department)

Name of Unit Head/ Manager of Department			
Position / Appointment			
Signature		Date	

H. Submission

Forward completed form to the Pharmacy department with supporting data and relevant protocol/guideline (if applicable).

For questions or discussions regarding this application, the Pharmacy Department may be contacted via:

Phone: []

Email: []

► *Forward completed form to the Pharmacy Department*

For Drug and Therapeutics Committee Use Only

Outcome of application process:

Process	Date / Details / Notes
Application received <i>(Date received by DTC secretary)</i>	
Application considered <i>(DTC meeting date)</i>	
Outcome:	<input type="checkbox"/> Approved <input type="checkbox"/> Rejected <input type="checkbox"/> Deferred
Conditions of approval <i>(Specify restrictions)</i>	
Approval review date <i>(If applicable)</i>	
Applicant advised of outcome <i>(Date)</i>	

Approved by:

Signed on behalf of Drug and Therapeutics Committee	
Name	
Date	