Prescriber Acknowledgement Form

Medicines Access Programs - SA Health

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Local Health Network/Health Service       |  | Hospital: |       |  |  |
| I,       (print name), hereby accept responsibility for prescribing the medicine       (medicine name) under the specified Medicines Access Program. Program name:     Sponsor/Company name: \_     Start date:       Stop date:      I understand that (please tick the following boxes): |
| [ ]  | I must provide both verbal and written information about the medicine and program to the patient. |
| [ ]  | I am required to obtain patient consent prior to accessing this medicine under the Medicines Access Program.  |
| [ ]  | The Medicines Access Program must be approved by the Local Health Network (LHN), hospital, or health service Drug and Therapeutics Committee (DTC) (or equivalent committee) prior to accessing this medicine under the Medicines Access Program. |
| [ ]  | Acceptance of this Medicines Access Program does not commit SA Health to subsequently place the medicine on the formulary. |
| [ ]  | If the program is terminated for safety or clinical reasons, I will discuss treatment options available through the usual SA Health medicines access pathways. |
| [ ]  | I agree to provide reports of the MAP to the LHN/health service DTC (or equivalent committee) according to the timing stipulated by the LHN, hospital, or health service DTC (or equivalent committee). The reports will include the number of patients participating in the MAP, adverse events experienced and effectiveness measures, and clinical outcome of the treatment. The final report must be signed by the lead clinician or delegate. |
| *The patient (please tick boxes):*  |
| [ ]  | Is aware that usual hospital medication charges will apply to items supplied under the Medicines Access Program. That is, a dispensing fee equivalent to the appropriate patient co-payment for a medicine supplied by the hospital. |

|  |
| --- |
| *Declaration of conflict of interest:* |
| [ ]  | I certify that I am aware of no potential conflict of interest which may arise in respect of this Medicines Access Program (please refer to SA Health Policy Directive: ‘Interaction between SA Health and the Therapeutic Goods Industry’ regarding conflict of interest).  |
| *OR* |
| [ ]  | I may have a conflict of interest for the following reason/s: *[e.g., receipt of research funds from a sponsoring company; receipt of ex-gratia payments or consultancy fees from a sponsoring company; overseas/interstate trips funded or subsidised by a sponsoring company; personal or family shares in the company sponsoring the product/s (or competing product/s) for which application is made].* Please identify any potential conflicts of interest: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  | I have made the patient aware of any potential conflict of interest I have in relation to this Medicines Access Program. |
|       |  |       |  |       |
| Doctor’s Name |  | Signature |  | Date |
|       |  |       |  |       |
| Witness’s Name |  | Signature |  | Date |
|  |       |  |
| If signing on behalf of a consultant, please write the consultant’s name. |