

3. Request for cover in full for non-formulary medication (Healthcare Professional to complete)

Please complete the table below where non-formulary medication is prescribed for the treatment of PMB CDL conditions and the request is for cover without a co-payment. Please supply additional information and supporting documentation where appropriate, as to why the formulary medication cannot be used by the patient, including details of treatment failure or adverse drug reactions where applicable.

Medication name and strength	Quantity	Supporting information for the request

Previous medication history

Medication name and strength	Date treatment with this medication was initiated	How long did the patient use the medication for?	Details of treatment failure or adverse drug reactions

4. Healthcare Professional's details (Healthcare Professional to complete)

Name and surname

Practice number Specialty

Telephone

E-mail address

The outcome of this application will be sent to you by e-mail

Healthcare Professional's signature

Date