

HIGHLY SPECIALISED DRUGS PROGRAM

Certification that the patient meets the Pharmaceutical Benefits Advisory Committee's criteria for prescription of

.....

Patient's Name:
Patient's ID Number:
Patient's Medicare Number:

I certify that the above named patient satisfies the Pharmaceutical Benefits Advisory Committee's clinical criteria for the prescription of:

(drug name).....

which limits it to:

(clinical indication).....

.....
.....
.....

Signature:Date:...../...../.....

Name:.....

Hospital:.....

In the case of authorised prescribers of HIV/AIDS and/or Hepatitis C drugs, the following should also be included.

Provider Number:.....

Address:.....

Phone:.....