Compassionate Access Request

RUA BIOSCIENCE

Please complete Parts A and C if enrolling a new patient or renewing an e-voucher.
Please complete Parts B and C only if ordering medical cannabis product for an active enrolment.
This form can be completed electronically and e-mailed to: rua@cdc.co.nz together with a copy of your practising certificate.

My patient is receiving palliative care and lives between Tolaga Bay and Potaka.

☐ YES ☐ NO

PART A - Obtaining, renewing, or cancelling an e-voucher

I am requesting: *(Please tick only one box per form)*

☐ First time enrolment of my patient in RUA's compassionate access programme

OR

☐ Renewal of the e-voucher for my enrolled patient whose:

NHI number is

E-voucher number is

OR

☐ Cancellation of the e-voucher for my enrolled patient whose:

NHI number is

E-voucher number is

PART B - Which specific medical cannabis product are you prescribing?

I wish to order the following number of medicinal cannabis product for compassionate supply for my patient .

1 ☐ 2 ☐ 3 ☐

(Check the box for the quantity required)

CBD products can be ordered and supplied by a pharmacist 3 months at a time, **THC products** are able to be ordered in quantities of 3, however only supplied 1 unit at a time.

Units of medical cannabis for my patient whose details are:

NHI number: Enter text.

Patient Name: Enter text.

e-voucher number: Enter text.

Please write name of product as per NZMQS list on MOH website linked HERE

PART C - Confirmation of eligibility for the programme.

I believe the following to be true:

a. My patient is resident in Tairāwhiti, and I am a doctor who is in the Hauora Tairāwhiti district.
b. My patient's condition may benefit, or has benefited, from treatment with medical cannabi and that treatment with this unregistered medicine (provided under section 29 of the Medicines Act) is a better clinical option for my patient than treatment with a registered medicine.
c. Affordability is presenting a significant barrier for my patient to access medical cannabis.
d. I will notify CDC to cancel my patient's enrolment in the programme if these statements cease to be true.

Signed (by prescriber):

Name of prescriber:

Name of medical pharmacy:

Street address of pharmacy: (for delivery of the medicine)

Email to: rua@cdc.co.nz **Rua Bioscience FAQ: HERE**