NOTICE OF INTENTION TO SEEK REIMBURSEMENT APPROVAL

This form has been prepared to enable manufacturers, importers or their agents to notify the HSE Corporate Pharmaceutical Unit of their intention to seek reimbursement approval for a product.

This form should be completed when submitting an application for a marketing authorisation or as soon as possible thereafter. It is understood that information at such as early stage may be very limited and provisional.

If the space available to answer a particular question is not adequate, please attach a continuation sheet - indicating the relevant question.

1.	**Full name, strength, form and pack size of medical product for which a marketing authorisation has been sought:**	
2.	**Active Ingredient:**	
3.	**Pharmacotherapeutic Group:**	
4.	**Therapeutic indications for which a marketing authorisation has been sought:**	
5.	**Any further relevant information:**	
6.	**Company Name:**	
7.	**Company Address:**	
8.	**Contact Name:**	
9.	**Telephone No:**	
10.	**Fax No:**	
11.	**Email Address:**	
12.	**Date New Medicine Horizon Scan submitted / will be submitted:**	

Signed: _____ **Date:** _____
Managing Director/General Manager

The completed form should be returned to:

Corporate Pharmaceutical Unit
HSE Primary Care Reimbursement Service
Exit 5 M50
North Road
Finglas
Dublin 11
D11 XKF3

Tel No: 353-1-8915725
Fax No: 353-1-8915757
E-mail: CPU@hse.ie

CPU Office Use Only - Date Stamp

Copies of this form are available on www.hse.ie/eng/about/Who/cpu