

Feidhmeannacht na Seirbhíse Sláinte Seirbhís Aisíoca Príomhchúraim Bealach amach 5 an M50 An Bóthar Thuaidh Fionnghlas Baile Átha Cliath 11

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Health Service Executive
Primary Care Reimbursement Service
Exit 5, M50
North Road
Finglas
Dublin 11

Tel: (01) 864 7100 Fax: (01) 834 3589

Circular 010/12 25th July 2012

Dear Doctor,

The HSE has approved reimbursement for Dabigatran and Rivaroxaban for their further indication(s) in circumstances where one of the products is used as a second line therapy when warfarin may not be appropriate.

These are the first of the new agents which probably represent the future for anticoagulation therapy. However they do present significant clinical, financial and operational challenges.

Warfarin remains the recommended first line agent reimbursed (including for newly diagnosed patients). Dabigatran or Rivaroxaban should be reserved for:

- 1. Existing patients on Warfarin with poor INR control despite adhering to monitoring and lifestyle requirements and documented attempts to optimise Warfarin therapy.
- 2. Existing patients who require regular periodic treatment with medicines that are known to interact with Warfarin.
- 3. Patients with a documented allergy to Warfarin.

Patient specific applications for reimbursement will be required from the physician responsible for the management of the patient's anticoagulation in each 'de novo' case prior to reimbursement approval. An application form for individual reimbursement has been developed in conjunction with the Clinical Strategy & Programmes Directorate to capture pertinent information. The form to request Individual Reimbursement Approval can be accessed in the coming days from www.pcrs.ie (online services) or by emailing pharmacy.response@hse.ie. A copy is included for your information.

The requirement for individual applications prior to reimbursement in the first phase of introduction of these new agents is designed to manage the financial challenges faced. Your cooperation is requested to ensure sufficient funding is available to support existing services provided by the HSE whilst also managing the introduction of these new agents.

Clinical experts have been requested to develop appropriate national protocols to guide reversal of excess anticoagulation / overdose and management of planned and emergency procedures.

A separate communication has been issued to the hospital system. The HSE will continue to update you in relation to these matters.

Yours sincerely,

Patrick Burke

Primary Care Reimbursement Service



Application Form for Individual Patient Reimbursement of a New Oral Anticoagulant by PCRS

All Sections must be completed in block capitals by the Prescriber responsible for Anticoagulation All contact details must be provided so that formal decision notification can be issued Form must be returned to the Primary Care Reimbursement Service, Exit 5, M50, Finglas, Dublin 11 **Patient Name** Patient Date of Birth (DDMMYYYY) **Patient Address GMS Number** Patient Identifier (at least one must be (Medical Card Number) provided) **DPS Number** (Drugs Payment Scheme) PPS Number Physician Responsible for Management of Anticoagulation **Medical Council Registration Number** Department / Speciality Hospital Address Prescriber Contact Details Landline: Mobile: Email Address: Signature Name of Oral Anticoagulant being requested Dose of oral anticoagulant Duration of anticoagulant therapy Specific Indication to be treated Please indicate ($\sqrt{\ }$) whether the patient has previously received Warfarin Yes No

Reason for switch to or de novo treatment with new oral anticoagulant (please provide written details plus specific information in relation to INR control, interacting medicines and / or details of documented allergy to warfarin)											
If the reason claimed is poor INR control	Date 1				INID 4						
please list the last 5 INRs and the actions taken to optimise INR control	(DDMMYYYY) Date 2				INR 1						
	(DDMMYYYY)				INR 2						
	Date 3 (DDMMYYYY)				INR 3						
	Date 4										
	(DDMMYYYY) Date 5				INR 4						
	(DDMMYYYY)				INR 5						
Actions taken to optimise INR control											
				_							
If the reason claimed is poor INR control (an)other essential medicine(s) please p								of			
Medicine 1 & reason for use											
Medicine 2											
& reason for use											
Medicine 3 & reason for use											
Medicine 4											
& reason for use											
Medicine 5 & reason for use											
If the reason claimed is allergy to warfar	in please pro	ovide spec	cific deta	ils includi	ing date of re	eporting to I	rish Medicines Bo	oard			
		For DC	CRS use o	nly							
			ks use o	шу							

			For I	PCF	RS us	e o
Date request received (DDMMYYYY)						
Is form completed in full?	Yes		No	,		
Does the request fall within PCRS authority?	Yes		No)		
Decision Made						
Decision notified to Patient	Yes		Dat	е		
Decision notified to Prescriber	Yes		Dat	е		