

Health Services Executive Primary Care Reimbursement Service

Special Drug Request User Registration Form

Before completing this form please read text below and notes on page three:

- (1) All fields are mandatory unless otherwise stated.
- (2) Please ensure forms are completed correctly in black ink and returned to PCRS.
- (3) The most frequent issues with these forms submitted to PCRS are incorrect completion of the Authorisation Section, illegible entries and missing entries.
- (4) Authorisation of access **must be** performed by the Centres CEO/Delegated person.



Primary Care Reimbursement Service Special Drug Request User Registration Form v8

Information and Data Protection Notice

- 1. Please read the notes on page three of this document before completing this form. All fields are mandatory unless otherwise stated.
- 2. Please use BLOCK CAPITALS and complete all sections. Forms which cannot be processed will be returned to sender by post.
- 3. **Data Protection Notice:** Personal data collected by the HSE is used for the purpose of providing a health service. It is required, stored, processed and disclosed to other bodies in accordance with the laws relating to proper treatment of personal data.

| storea, processed | a ar | na a | IISCI | ose | d to | oth | er b | oale | es ir | n ac | cord | ano | ce w | ith t | ne i | aws | rei | atın | g to | pro | per | trea | itme | ent (| от р | erso | onai | data | Э. — | | | |
|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------|------|------|-------|-------|------|-------|-------|-------|-------|------|----------|-----------|-------------|----------|------------------|-------|------------------|-----|------------------------|------|-------|------|-------|------|--------|---------|--|--|--|
| Part 1: Applicant Details | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Forename | | | | | | | | | | | | | | Su | ırna | me | | | | | | | | | | | | | | | | |
| Department | | | | | | | | | | | | | | Position | | | | | | | | | | | | | | | | | | |
| Employee No. | | | | | | | | | | | | | | Ph | one | e No |). | | | | | | | | | | | | | | | |
| Professional Reg | gist | trati | on | Nur | nbe | r (i. | e. n | nedi | ical | СО | unc | il, C | OR | U) | | | | | | | | | | | | | | | | | | |
| Work address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (see note one) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| , , | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Email Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Email Address (work email | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| only) | <u> </u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Username | _ | | | | | | | | | | | | | | | | | | | | | | | | | | | \Box | | | | |
| (existing users only) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part 2: Role | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please select the ac | | Access | | | | | | | | | | | | | | | <u> </u> | Tick if Required | | | | | | | | | | | | | | |
| | . | Entresto (Sacubitril/Valsartan) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Fampridine CGM Sensors & Diabetic Test Strips | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Lidocaine 5% Plasters (Versatis®) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Lidocaine 5% Plasters (Versatis®) Non-first line Oral Nutritional Supplements | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | PrEP (Approved Prescribers Only) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Rivaroxaban 2.5 mg | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Saxenda (Liraglutide) 6 mg/ml Injection | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| High Tech Hub Drug | | PCSK9 Inhibitors | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (Approved Prescriber | | CGRP MABs (Migraine Treatments) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Atopic Dermatitis (e.g. abrocitinib, dupilumab, tralokinumab upadacitinib) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Sativex Oromucosal Spray | | | | | | | | | | | | | | | 1 | | | | | | | | | | | | | | | |
| | | Severe Asthma (Dupilumab) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part 3: Centre | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please enter the r | nam | ne o | of the | e Ho | ospi | tal c | or C | НО | whe | ere : | you | req | uire | app | rov | al to | ac | ces | s the | Sp | eci | al D | rug | Re | que | est s | yste | m | | | | |
| Hospital/CHO Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part 4: Use | Part 4: User Declaration | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I understand that to the standards w | aco | cess | s. I a | am f | ully | awa | are c | f da | ata p | | | | | | | <u>A</u> p | pli | can | t S | <u>Signature</u> | | | | | | | | | | | | |
| my responsibilities | | _ | | - | | rrec | t us | e ar | ıd a | ICCE | ess (| JT CI | ient | uata | 1. | | | | | | | | | | | | | | | | | |
| Part 5: Aut | Part 5: Authorisation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I, the CEO (or my delegate) at the above C provided with access which will allow her/hi | | | | | | | | | | | | | | | | | | | | | | CEO/Delegate Signature | | | | | | | | | | |
| that all appropriate physical security arrangements | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| infrastructure. | | | | | | | | | | | | | | | | <u>Date</u> | | | | | | | | | | | | | | | | |
| RETURN TO CI | ER' | <u>T.IN</u> | NFC |)@ | HSI | E.IE | | | | | | | | | | | | | | | | | | | | | | | | | | |

OFFICIAL USE ONLY Approved by: Date:

Ref Number:

Applicants User ID:



Health Services Executive Primary Care Reimbursement Service

Special Drug Request – User Registration Form

Notes on this User Registration Request Form:

- 1. Only fully completed request forms will be processed. All fields are mandatory unless otherwise stated. Incomplete forms will be returned to sender by post. Please note that if the "Office Address" is not provided, forms cannot be returned and no further action can be taken by PCRS.
- 2. Authorisation Section: Authorised signatory grades for the purpose of this form are at minimum:
 - a. Hospital CEO
 - b. General Manager
- 3. Certain temporary staff may not have employee numbers. In these cases "Not Available" may be inserted.
- 4. Completed and signed forms should be scanned, attached and emailed to the Primary Care Reimbursement Service at cert.info@hse.ie. Alternatively, they can be posted to IT Operations, PCRS, Exit 5 M50, North Road, Finglas, Dublin 11. Forms will not be accepted by fax.
- 5. Only the single point of contact with PCRS should complete this form.