Australian Government
Department of Health and Aged Care

Life Saving Drugs Program
Change of Treating Physician

APPLICATION FORM FOR CHANGE OF TREATING PHYSICIAN

About this Program
The Life Saving Drugs Program (LSDP) is administered by the Department of Health and Aged Care (the Department).

It is recommended that you read the LSDP Guidelines for the relevant medicine your patient is receiving before completing this form.

Purpose of this form
The purpose of this form is to facilitate an existing patient's transition of care to a new treating physician where there are no other changes to the patient's treatment or eligibility information previously provided to the LSDP.

If you are a treating physician for a new patient please do not use this form. Please complete the initial application form for the relevant medicine found on the Department's website at www.health.gov.au/lsdp

Filling in this form
This application form must be filled out by the new treating physician with relevant specialist registration when a patient is transferring care, with the consent of the patient or parent/guardian. The patient or their parent/guardian is required to sign the application form to provide consent to the Department to collect personal information.

- Please complete electronically, print and sign; or
- Use black or blue pen and print in BLOCK LETTERS. All pages of the form must be completed and submitted. Incomplete forms will not be processed.

For more information
For more information go to the Department's website www.health.gov.au/lsdp

If you need assistance completing this form, or for more information call **(02) 6289 2336,** Monday to Friday, between 9.00 am and 5.00 pm, Australian Eastern Time.

Returning your form

Send the completed form:

By email to: **lsdp@health.gov.au**

By fax to: **(02) 6289 8537**

Patient's details

LSDP Patient ID

Medicare card number

Ref no.

Mr Mrs Miss Ms Other

Given Name

Family Name

Residential address

Suburb State Post Code

Previous treating physician's name

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New treating physician's details

Prescriber number

Given name

Family name

Work phone number

Mobile phone number

Email address

Hospital/Department

Postal address

Suburb | State | Post Code

Clinic nurse details

Given name

Family name

Work phone number

Email address

Hospital/Department

Postal address

Suburb | State | Post Code

Pharmacist's details (if changed)

Given name

Family name

Work phone number

Email address

Hospital/Department

Delivery address (for LSDP stock)

Suburb | State | Post Code

Secondary pharmacy contact's details

Given name

Family name

Work phone number

Email address

Dosing details

Generic name of medicine treatment requested:

Patient's weight kg | Patient's height cm

Dosage of medicine treatment requested: (e.g. x mg/week)

Number of vials per dose (for ordering purposes)

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Patient Consent

Consent to collection of sensitive information for treatment and after cessation of treatment

I consent to the Department collecting genetic and health information about the patient identified on this application form for the purpose indicated above.

I consent to the Department requesting and obtaining sensitive information and supplemental information from my treating physician regarding the reason(s) for ceasing treatment including cause of death, if applicable.

If this information is not able to be obtained from my treating physician, I consent to the Department requesting and obtaining this information from other Government agencies and non-government organisations.

The information collected in this process is for the purpose of determining the cause of discontinuation of subsidised treatment.

Continuing eligibility for subsidised treatment under the LSDP

I understand that:

- If I fail to comply with the associated monitoring and assessment requirements, without an acceptable reason to do so, I will no longer be eligible to receive subsidised treatment through the LSDP.
- I understand that if treatment does not result in a clinically meaningful effect, LSDP treatment may be discontinued.

Signature

Patient ☐ Parent ☐ Guardian ☐ (tick one only)

Full name (print in BLOCK LETTERS)

Date

New Treating Physician's Declaration

I confirm that:
I am the new treating physician of the patient as stated in this form, and have relevant specialist registration.

I declare that:
The information provided in this form is complete and correct.

To the best of my knowledge and belief, my patient is eligible to receive subsidised treatment through the LSDP in accordance with the Guidelines for the relevant medicine.

I am aware that the patient must be an Australian citizen or permanent Australian resident who continues to qualify for Medicare.

I understand that:
I have an ongoing obligation to ensure that my patient continues to meet the eligibility criteria to receive subsidised treatment through the LSDP.

Making a false or misleading declaration is a serious offence and may lead to further investigations.

I must submit a reapplication form for subsidised treatment through the LSDP by 1 May each year if I wish for my patient to continue to receive subsidised treatment.

I agree that:
If I become aware that my patient no longer meets the eligibility criteria for subsidised access to treatment through the LSDP at any time, I will notify the Department immediately in writing.

New treating physician's full name

New treating physician's signature

Date

Version date: January 2023