15TH NATIONAL HEALTH FUND
HEAD OFFICE: 6TH Floor, The Towers, 25 Dominica Drive, Kingston 5
Tel: (876) 906-1106 Fax: 906-1105 Toll-free 1-888-342-5643
PHARMACEUTICAL DIVISION: 78 Marcus Garvey Drive, Kingston 11
Website: www.nhf.org.jm

November 2018

Dear Applicant,

We value your interest in the National Health Fund (NHF) and to this end, we commit to ensuring our application process is concise and easily understood as you seek to partner with us in doing business. The NHF's Drug Application Form, seen below, is to be accurately completed and presented along with the following:

1. Cover letter
2. Copy of the Pharmaceutical Product License issued by the Ministry of Health
3. Picture of the product
4. Product literature (may include package insert)
5. Clinical Studies (applicable for new active pharmaceutical ingredients only)

N.B. A National Drug Code should be assigned prior to submission of an application.

Applications for new active pharmaceutical ingredients will become eligible for consideration one year after the commencement date of product sales in the local market.

Kindly be reminded, where there is a change in any product covered on the programme, by way of label name, strength, presentation, pack size and/or manufacturer, a new application will be required. For changes in pack size, requirements two and four above are not mandatory. An application form should not contain more than two strengths or pack sizes. Additionally, we ask that you inform the Individual Benefits Manager if there are any particular issues relating to your product that would be of concern to the National Health Fund. Please note, if the pharmaceutical is not yet available in the island, and has not been assigned a National Drug Code, processing of the application will not commence. Be assured, once the application process review is completed, you will be informed of the decision.

Thank you for your interest in the National Health Fund.

Yours sincerely,

Kathrine Dawson Shaw
Individual Benefits Manager

Att.

NHF DRUG APPLICATION FORM

PROPRIETARY NAME OF DRUG: _____

ACTIVE PHARMACEUTICAL INGREDIENT: _____

STRENGTH(S): _____

DOSAGE FORM: _____

PACKAGE SIZE: _____

DRUG CLASSIFICATION: _____

MANUFACTURER: _____

DISTRIBUTOR: _____

DISTRIBUTOR'S PRICE: _____

CATEGORY OF PHARMACEUTICAL: ☐ **Innovator Drug** ☐ **Generic Drug**

COUNTRY OF ORIGIN: _____

ARE OTHER BRANDS OF THE SAME ACTIVE INGREDIENT BEING SOLD IN JAMAICA? ☐ **Yes** ☐ **No**

IS THE PHARMACEUTICAL CURRENTLY BEING SOLD IN JAMAICA? ☐ **Yes** ☐ **No**

IF YES, INDICATE COMMENCEMENT DATE OF SALES IN JAMAICA: (MONTH/YEAR) _____/_____

HAS THE PHARMACEUTICAL BEEN ASSIGNED A DRUG CODE? ☐ **Yes** ☐ **Uncertain** ☐ **No**

IF YES, WHEN (MONTH/YEAR) _____/_____

HAS THERE BEEN A PREVIOUS APPLICATION FOR THIS PRODUCT? ☐ **Yes** ☐ **No**

IF YES, WHEN (MONTH/YEAR) _____/_____

IS THIS A CHANGE TO AN EXISTING DRUG ON THE NHFCARD PROGRAMME? ☐ **Yes** ☐ **No**

IF YES, KINDLY TICK THE APPROPRIATE CHANGE(S):

NAME ◯ **STRENGTH** ◯ **DOSAGE FORM** ◯ **PACK SIZE** ◯ **PRESENTATION** ◯

IS THIS REPLACING AN EXISTING PRODUCT ON THE NHFCARD PROGRAMME? ☐ **Yes** ☐ **No**

INDICATION(S): _____

MAIN SIDE EFFECTS: _____

_____

_____

CONTRAINDICATIONS & PRECAUTIONS: _____

_____

NAME OF PHARMACEUTICAL COMPANY: _____

NAME OF APPLICANT: _____

POSITION: _____

EMAIL ADDRESS: _____

DATE OF APPLICATION: _____ **SIGNATURE OF APPLICANT:** _____

FOR OFFICE USE ONLY

DATE OF APPROVAL: _____ **BOARD OF MANAGEMENT** ◯ **Sr. MANAGEMENT** ◯

DATE OF ADDITION TO THE NHF DRUG LIST: _____

APPROVED DRUG SUBSIDY/SUBSIDIES _____

DATE ON WHICH THE APPLICANT WAS NOTIFIED: _____

SIGNATURE: _____