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| |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 附表18 | | | | | | | | | | | | | | | | | | | | | | 基本医疗保险高值药品事前审核表 | | | | | | | | | | | | | | | | | | | | | | 本人申请 | 姓名 |  | | 性别 | |  | | 年龄 |  | | | 身高 | | |  | | 体重 | |  | | 身份证号码 |  | | | | 单位名称 | |  | | | | | | | 医保编码 | |  | | | | | 治疗机构名称 |  | | | | | | 参保地医保经办机构名称 | | | | | | |  | | | | | | | 事前审核的病种 | | | | | | | | | | | | | | 医生签章  年 月 日 | | | | | | |  | | | | | | | | | | | | | | | 治  疗  机  构  意  见 | 事前审核通过的病种 | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | 事前审核未通过病种 | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | 建议治疗方案 | | | | | | | 填表说明 | | | | | | |  | |  | | | | | 药品通用名 | | | |  | | |  | | | | | | |  | |  | | | | 药品商品名 | | | |  | | |  | | | | | | |  | |  | | | | 剂量 | | | |  | | | 单次用药剂量 | | | | | | |  | |  | | | | 频次 | | | |  | | | 如每日一次、每周两次等 | | | | | | |  | |  | | | | 给药途径 | | | |  | | | 如口服、静脉注射等 | | | | | | |  | | (公章) | | | | 一次治疗周期天数（天） | | | |  | | | 一次治疗所需的天数 | | | | | | |  | |  |  | | | 治疗周期数 | | | |  | | | 需要治疗的周期数 | | | | | | |  | |  |  | | | 治疗周期（天） | | | |  | | | 治疗周期=一次治疗周期天数\*治疗周期数 | | | | | | |  | | 年 月 日 | | | | 医保经办机构意见 | 1.通过事前审核的参保人员，应及时到定点医疗机构申请治疗，病种认定有效期为1年,到期后若还需要使用相应药品、审核通过后超过6个月未进行治疗或出现中断治疗达到6个月以上的,均应重新申请事前审核；  2.治疗机构需建签名台账或实行电子签名；  3.此表可打印给参保人员留存；  4.治疗周期（天）参照不超过《单行支付药品及高值药品适用病种及用药认定标准》中每个药品治疗评估周期，且不超过一个治疗年度。 | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | |  | |  | 经办机构签章： | | |  | |  |  | |  | | | | |  | |  | |  | |  | 事前审核通过时间 | | | 年 月 日 | | | | | | | | | | 患者签名 |  | | 联系  电话 | |  | | | | | 联系  地址 | | | |  | | | | | | | |