Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

12 December 2016

DEPARTMENT MEMORANDUM
No. 2016 - 0443

TO : **ALL REGIONAL DIRECTORS**

ATTENTION: **CHIEF PHARMACISTS, NEUROLOGISTS, HOSPITAL DIRECTORS AND MEDICAL CENTER CHIEFS REQUESTED TO BE INCLUDED IN THE STROKE MEDICINES ACCESS PROGRAM (StrokeMAP)**

SUBJECT : **Stock Transfer of Alteplase Products under the Stroke Medicines Access Program (StrokeMAP)**

The Department of Health (DOH) through the Pharmaceutical Division (PD) issued Department Memorandum No. 2016-0242 declaring that the Alteplase products shall be given free for all clinically eligible patients. Due of this directive, the average consumption of Alteplase increased from from 8 vials to 25 vials per month.

Despite the interventions, the Pharmaceutical Division has noted the slow movement of Alteplase which the hospitals forecasted for 2015. To increase the reach of the program to more needy patients who may be going to other hospitals, whether public or private, these guidelines are being issued as a guide to hospitals on how to execute a Deed of Donation and stock transfer to other hospitals:

1) Transfer to a Government Facility - Stock transfer form (Appendix A) shall be used if you are going to transfer alteplase products to DOH-retained hospitals and other government health facilities. Kindly refer to the DOH official website **http://www.doh.gov.ph** for the complete list of hospitals under the DOH.

Identify DOH-retained hospitals with high utilization of Alteplase (see list of StrokeMAP Access Sites – Appendix F) and/or other government hospitals. Once identified, a letter of request addressed to the Secretary of Health, attentioned to your Medical Center Chief/Hospital Director must be sent to your hospital stating that they need the said high cost medicine

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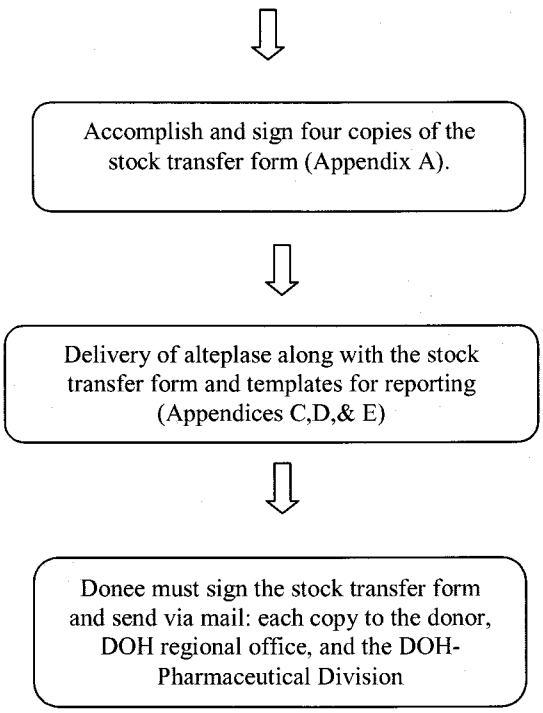
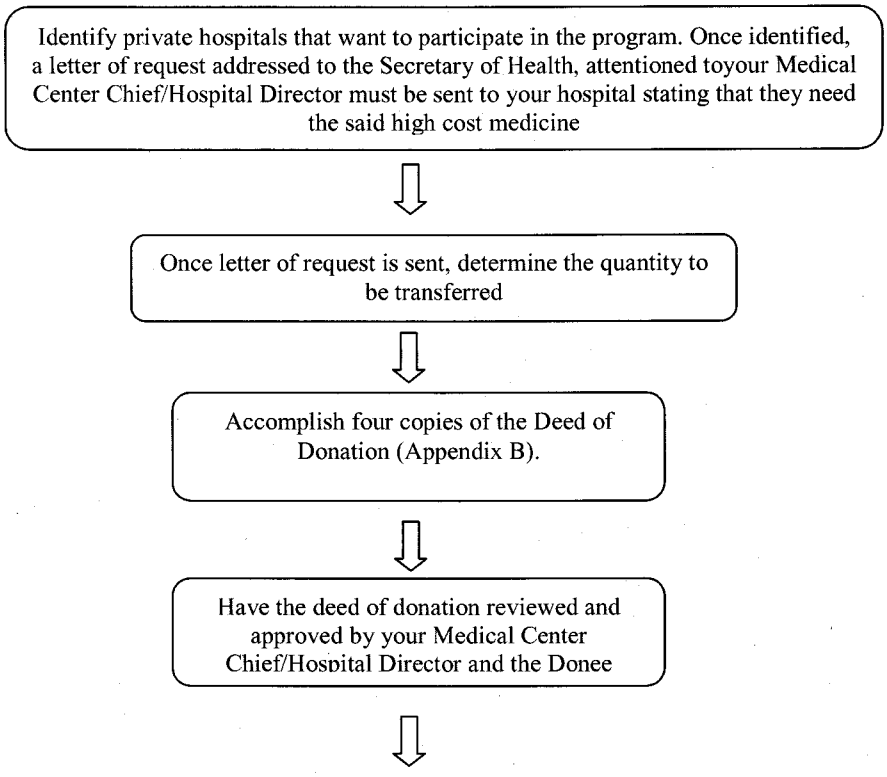
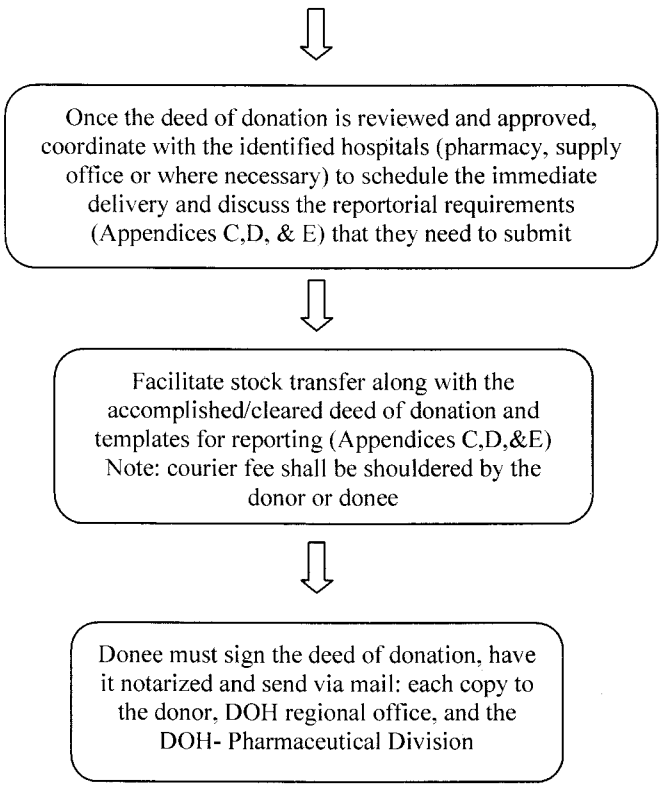
Once the letter of request is sent, coordinate with the identified hospitals (pharmacy, supply office or where necessary) to schedule the immediate delivery and discuss the reportorial requirements (Appendices C, D, & E) that they need to submit to your hospital copy furnished the DOH – Pharmaceutical Division
Note: courier fee shall be shouldered by the donor or donee



2) Transfer to a private institution - Deed of Donation (Appendix B) shall be used if you are going to transfer alteplase products to private institutions. Please be reminded that before doing this kind of transaction, an accomplished deed of donation must be cleared by your Medical Center Chief/Hospital Director. Once the stocks are donated, you are responsible in collecting the reports of private institutions particularly the utilization report (Appendix C), patient beneficiary list (Appendix D) and Patient Consent Form (Appendix E). All reports must be submitted to your hospital every month.





For strict compliance.

By Authority of the Secretary of Health:

AGNETTE P. PERALTA, MSc., CESO III
Assistant Secretary of Health
Office for Health Regulation

APPENDIX A

Republic of the Philippines
Department of Health

Stroke Medicines Access Program
Stocks Transfer Form (For Government to Government Transaction)
Name of Hospital: _____

Utilization Used:

[ ] Transferred to ( ) other RHU ( ) Hospital ( ) other Health Facility

Name of Recipient: _____

Item No.	Name of Medicine	Batch or Lot Number/s	Expiration Date/s	Quantity
			TOTAL	

Reason of Transfer: [ ] Oversupply [ ] Cannot be consumed before its Expiry Date
[ ] Other reasons
Please specify: _____

Prepared by: _____

Date: _____

Received by: _____

Date: _____

Noted by: _____

Date: _____

Note:

*Furnish four (4) original copies

APPENDIX B

DEED OF DONATION

This deed of donation made and executed by and between;

MEDICAL CENTER CHIEF/HOSPITAL DIRECTOR

(Name of Hospital), with office address at **(hospital address)** represented in this Act by its representative, **(Medical Center Chief/Hospital Director)**, hereinafter referred to as the **DONOR**;

-and-

The **(Name of Hospital)** , with office address at **(hospital address)**, represented in this Act by its representative, **(Hospital CEO/Chief)** referred to as the **DONEE;**

WITNESSETH, that

WHEREAS, the 1987 Constitution of the Republic of the Philippines mandates that the State shall protect and promote the right to health of the Filipino people and instill health consciousness among them;

WHEREAS, RA No. 9502, otherwise known as the Universally Accessible Quality and Cheaper Medicines Act of 2008 mandates the Department of Health (DOH) to increase access to essential medicines for the country's priority diseases;

WHEREAS, Diseases of the Vascular System including Cerebrovascular Accident (CVA) or Stroke are the second leading cause of mortality according to the 2009 Philippine Health Statistics of the Department of Health (DOH). In the study done by the World Stroke Organization, this medical condition is among the top five diseases with the greatest burden;

HOSPITAL CEO/CHIEF

WHEREAS, the Department of Health (DOH) is now implementing a free medicines access program for vulnerable and special population affected by diseases which cause a significant health and economic burden in the country;

WHEREAS, (Name of Hospital/Donee), greatly values the partnership of DOH in implementing this important public health initiative that shall benefit the majority of the Filipino patients, especially those who have no access to affordable and quality drugs and medicines;

WHEREAS, the DOH, through government hospitals like (Name of Hospital/Donor), is implementing the Stroke Medicines Access Program (StrokeMAP) to make Alteplase readily available to health facilities with adequate expertise and equipment in treating Cerebrovascular Accident (CVA) at the first few hours of its occurrence. Thus, this Program will undergo pool procurement of this high-cost medicine which aims to bring down its cost in the market and to provide free alteplase to stroke patients especially the underprivileged.

-and-

WHEREAS, the DONOR hereby donates on (date) **:**

QTY	Unit	Item Description	Packaging
(__)	box	Human Recombinant Tissue Type Plasminogen Activator/Alteplase 50 mg vial + sterile water for injection 50 mL vial	1 vial human recombinant tissue type plasminogen activator/ alteplase + 1 vial sterile water for injection per box

WHEREAS, the DONOR is donating the aforementioned property subject to the following terms and conditions:

1. The DONEE shall serve as an Expansion Access Site for the StrokeMAP.
2. No alteplase products donated shall be sold to patients, to the StrokeMAP access sites and expansion sites, hospital pharmacies or other drug establishments. The product shall bear a marking: **"Philippine Government – DOH Property Not For Sale"**.
3. The DONEE shall serve as an Expansion Access Site for the StrokeMAP.
4. The DONEE shall ensure that the following basic requirements for an Expansion Access Site to implement the StrokeMAP are complied with:
   a. Pharmacy services with proper storage and inventory system;
   b.Neurologist/Cardiologist/Internist who has expertise in proper administration of alteplase;
   c. Acute stroke unit; and
   d.Computed Tomography (CT) scan and other basic diagnostic ancillary services for StrokeMAP patients
5. The DONEE shall develop hospital guidelines for StrokeMAP which shall include the system for dispensing, recording and overall management to facilitate proper implementation.
6. The DONEE shall orient all health care providers involved in the implementation of Stroke Medicines Access Program in their respective institution.
7. The DONEE shall accept the custody of alteplase vials. No storage fee or any other fees for safekeeping and handling shall be charged to the DONOR.
8. The DONEE has full accountability of donated alteplase vials. Any loss, damage or breakage of alteplase vials shall be properly recorded and reported to the DONOR.
9. The DONEE shall prioritize members of the poor families enlisted under the PhilHealth sponsored program members, NHTS members, PWDs and Senior Citizens.
10. The DONEE must submit Utilization Reports and Patient/Beneficiary list on a monthly basis to the DONOR.

MEDICAL CENTER CHIEF/HOSPITAL DIRECTOR

HOSPITAL CEO/CHIEF

ACCEPTANCE

The DONEE hereby ACCEPTS the above-described property subject to the mentioned terms and conditions.

In Witness whereof, the parties hereto have caused this Deed of Donation to be duly executed on this ____ day of _____, 2016, in the City/Municipality of (_____), Philippines.

(Name of Hospital)	**(Name of Hospital)**
DONOR	**DONEE**
By:	**By:**
(Medical Center Chief)	**(Hospital CEO/Chief)**

ACKNOWLEDGEMENT

REPUBLIC OF THE PHILIPPINES)
_____) S.S.

BEFORE ME, a Notary Public for _____this _____ of 2016 personally appeared the following:

Name	Government ID No.	Date/Place Issued
Medical Center Chief/Hospital Director		
Hospital CEO/Chief		

Known to me and known to be the same persons who executed the foregoing instrument and who acknowledged to me that the same are their free and voluntary acts and deeds and that of the entities, which they respectively represent.

This instrument refers to Memorandum of Agreement consisting of (____) pages, including the page where this Acknowledgment is written, and is signed by the parties and their instrumental witnesses.

IN WITNESS WHEREOF, I have set my hand and affixed my seal on the date and place above written.

Doc. No. _____
Page No. _____
Book No. _____
Series of 2016.

APPENDIX C

Republic of the Philippines
Department of Health

OFFICE FOR HEALTH REGULATION – PHARMACEUTICAL DIVISION

UTILIZATION/STOCKS INVENTORY REPORT
For the Stroke Medicines Access Program

Name of Hospital: _____ **Covering Dates:** _____

Address: _____

Medicine	Delivery Date	Quantity Delivered	Stock on Hand	Number of Human Recombinant Tissue Type Plasminogen Activator/Alteplase vial (Month)	End of month stocks
Human Recombinant Tissue Type Plasminogen Activator/Alteplase 50 mg vial					

Prepared by:

_____ _____
Name/Signature **Date**
(Designation)

Approved by:

_____ _____
(Medical Center Chief /Hospital Director) **Date**

APPENDIX D
Republic of the Philippines
Department of Health

OFFICE FOR HEALTH REGULATION – PHARMACEUTICAL DIVISION

Stroke Medicines Access Program – Patient/Beneficiary List

NAME OF HOSPITAL											
ADDRESS											
DATE	**NAME**	**AGE**	**GENDER**	**ADDRESS**	**CONTACT NUMBER**	**NUMBER OF VIALS GIVEN**	**RECEIVED BY**	**NIH Stroke Scale**			**No. of Days of Hospitalization**
								Prior to treatment	**24 hours post treatment**	**Upon discharge**	

Prepared by:

_____
(Designation)

Approved by:

_____
(Designation)

Noted by:

_____
(Designation)

APPENDIX E-1

PATIENT CONSENT FORM

Patient Full Name: _____
Attending Physician: _____
Hospital Name: _____
Date: _____

1. I hereby agree, consent, and authorize _____ (hospital) to provide access to all information provided by me to the program administrators for the sole purpose of administration of the DOH - Stroke Medicines Access Program for which I (or the patient) have made this application.
2. I agree that my participation (or participation for my patient) in the DOH - Stroke Medicines Access Program is completely voluntary.
3. By signing this form, I certify and attest that all information I have given, including my (or patient's) medical and financial history and current status, is complete, true and accurate to the best of my knowledge.
4. I understand that I may be contacted to provide additional information and/or documents to verify my (or patient's) financial or insurance status, to determine my (or patient's) eligibility for the DOH – Stroke Medicines Access Program.
5. I understand that I may be contacted by the Department of Health (DOH)/Hospital to provide additional information of my (or patient's) whereabouts for monitoring of my (or patient's) status and to remind me of my (or patient's) next appointments.
6. I agree that all of the information provided by me for DOH – Stroke Medicines Access Program will be used to verify and decide if I (the patient) can participate in DOH – Stroke Medicines Access Program and, if I am (or the patient) admitted into the Program, to provide free alteplase to me (or the patient).
7. I understand that any side effects and risk factors that were discussed by the doctor can happen to me (or my patient) when alteplase is administered, that I will pursue this treatment despite the said risks.
8. I understand that my (or patient's) information will be included in the list of beneficiaries to be posted in the DOH website and for verification of my (or patient's) financial and medical eligibility to be admitted into DOH – Stroke Medicines Access Program.
9. I commit to comply with the treatment regimen that will be provided to me (or the patient) through the DOH - Stroke Medicines Access Program.
10. I understand that only free alteplase is covered by the DOH – Stroke Medicines Access Program.
11. I understand that diagnostic, laboratory examinations and other routine care costs are not included in the program, that these can be covered through the hospital medical social service, PhilHealth sponsorship program or any other medical assistance programs of the government.
12. I agree to provide all the relevant information to my (or patient's) physician that concerns my (or patient's) condition and current treatment that will contribute to the side effects and risk factors caused by alteplase.
13. I understand that the doctor/s and nurse/s are not liable if any untoward incident happens to me (or the patient) if I (or the patient) did not come during the scheduled appointments.
14. I commit to follow the agreement that I (or the patient) will come to all the appointments that is scheduled by the doctor.

I have read, in language understandable to me, the above information. The content and meaning of this information has been fully explained to me.

Patient's Signature: _____ Date: _____
Witness Signature: _____ Date: _____

APPENDIX E-2

Consent Form in Filipino

KASULATAN NG PAGBIBIGAY NG PAHINTULOT NG PASYENTE

Buong Pangalan ng Pasyente:_____
Pangunahing Manggagamot:_____
Pangalan ng Ospital:_____
Petsa:_____

1. Sa pamamagitan nito, ako ay sumasang-ayon at nagbibigay pahintulot sa _____ (Ospital) na makuha ang lahat ng impormasyon na ibinigay ko sa taga-pamahala ng programa para sa layunin ng DOH –Stroke Medicines Access Program, kung saan ako (o ang pasyente ko) ay nais sumali.
2. Ako ay sumasang-ayon na sa aking pagsali (o pagsali para sa aking pasyente) at kung ito ay naaprubahan, ang aking pagsali (o pagsali para sa aking pasyente) sa DOH - Stroke Medicines Access ay boluntaryo.
3. Sa pagpirma ko nito, aking pinapatunayan na ang lahat ng impormasyon na aking ibinigay kasama ang aking (o ang pasyente) medikal at pinansyal na rekord at kasalukuyang estado ay kumpleto, totoo at wasto sa abot ng aking kaalaman.
4. Aking nauunawaan na ako ay maaring makontak upang magbigay ng dagdag na impormasyon at/o dokumento para patotohanan ang aking (o ang pasyente) estadong pangpinansyal o *insurance* upang matukoy ang pagiging karapat-dapat para sa DOH- Stroke Medicines Access Program.
5. Aking nauunawaan na ako ay maaaring makontak ng Kagawaran ng Kalusugan o ng hospital upang magbigay ng dagdag na impormasyon kung saan man ako (o ang pasyente) nakatira upang malaman ang aking (o ng pasyente) kalagayan at paalalahanan sa mga susunod pang tsekap.
6. Ako ay sumasangayon na ang lahat ng impormasyon na aking ibinigay sa pag-aplay para sa DOH - Stroke Medicines Access Program ay magagamit upang mapatotohanan at mapagdesisyunan kung ako (o ang pasyente) ay maaring maisali sa DOH – Stroke Medicines Access Program, at kung ako (o ang pasyente) ay maisali sa programa ay mabigyan ng libreng alteplase.
7. Aking nauunawaan na may maaaring pangalawang epekto na mangyari sa akin (o sa pasyente) dulot ng alteplase, na aking ipagpapatuloy ang pagbibigay sa akin (o sa pasyente) ng gamot na ito kahit ito ay may pangalawang epekto.
8. Aking nauunawaan na ang aking (o ang pasyente) impormasyon ay maisasama sa listahan ng pasyente/benepisyaryo na ilalagay sa DOH website at para tiyakin na ang aking (o ang pasyente) pinansyal at medical na kalagayan ay karapat-dapat para maisali sa DOH – Stroke Medicines Access Program.
9. Ako ay nangangako na tutupad sa aking mga gamutan na ibibigay mula sa DOH - Stroke Medicines Access Program magmula sa umpisa ng aking gamutan hanggang sa mga itatakdang araw ng aking pagbalik.
10. Aking naiintindihan na ang libreng alteplase lamang ang kasama sa programang ito.
11. Aking naiintindihan na ang dyagnostiko, pagsusuri na ginagamitan ng laboratoryo at iba pang pinagkakagastahan sa pagpapagamot ay hindi sakop ng programang ito, na ito ay maaaring ilapit sa Hospital Medical Social Service, Philhealth Sponsorhip Program o iba pang pangsuportang medikal na programa ng gobyerno.
12. Ako ay sumasangayon na aking ibibigay ang lahat ng nauukol na impormasyon sa aking (o pasyente) doctor na may kinalaman sa aking kundisyon at gamutan na maaaring makaapekto o makadagdag sa pangalawang reaksyon na maaaring maidulot rin ng alteplase.
13. Aking naiintindihan na walang pananagutan ang mga doctor at narses kung may mangyari sa akin kung hindi ako bumalik sa itinakdang araw ng tsekap.
14. Ako ay nangangako na sundin ang mga napagkasunduan na ako ay babalik sa lahat ng mga itinakda pang mga araw ng tsekap ng doktor.

Aking nabasa, sa wikang aking nauunawaan ang lahat ng mga impormasyon nakasaad sa itaas. Ang nilalaman at kahulugan ng mga impormasyon ay naipaliwanag ng mabuti sa akin.

Lagda ng Pasyente: _____ Petsa: _____

Lagda ng Saksi:_____ Petsa: _____

APPENDIX F

List of Stroke Medicines Access Program (StrokeMAP) Access Sites

1. East Avenue Medical Center
2. Philippine Heart Center
3. Jose R. Reyes Memorial Medical Center
4. National Kidney and Transplant Institute
5. Quirino Memorial Medical Center
6. Las Piñas General Hospital and Satellite Trauma Center
7. Philippine General Hospital
8. Ilocos Training and Regional Medical Center
9. Mariano Marcos Memorial Medical Center
10. Region I Medical Center
11. Baguio General Hospital and Medical Center
12. Cagayan Valley Medical Center
13. Southern Isabela General Hospital
14. Jose B. Lingad Memorial Regional Hospital
15. Dr. Paulino J. Garcia Memorial Research & Medical Center
16. Batangas Medical Center
17. Bicol Regional Training and Teaching Hospital
18. Bicol Medical Center
19. Gov. Celestino Gallares Memorial Hospital
20. Corazon Locsin Montelibano Memorial Regional Hospital
21. Western Visayas Medical Center
22. Western Visayas State University Medical Center
23. Zamboanga City Medical Center
24. Cotabato Regional and Medical Center
25. Northern Mindanao Medical Center
26. Mayor Hilarion A. Ramiro Sr. Regional & Teaching Hospital
27. Davao Regional Medical Center
28. Southern Philippines Medical Center