



CHILDREN'S KIDNEY FUND

兒童腎病基金

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Tel : 2 3 6 9 4 9 2 8

Website: <http://www.childrenkidneyfund.org.hk>

『利妥昔單抗 (或其生物仿製藥) 資助計劃』

Subsidy for Rituximab (or its Biosimilar)

資助申請表格

Application Form

請將填妥表格電郵至 info@childrenkidneyfund.org.hk，並將正本寄至以上基金郵遞地址。

Please email the completed form to info@childrenkidneyfund.org.hk, with a hard copy mailed to the Fund address by post.

1. 申請人 (病童) 資料

Information on Applicant (Patient)

姓名： (中)：

Name Chinese

(英)

English

性別：

Sex

出生日期：

Date of Birth

出生證明書 / 身份證號碼* (請刪去不適用者)：

Birth Certificate / Identity Card No. * (Delete as Inappropriate)

居住地址：

Residential Address

電話：

Tel. No.

2. 申請人父母／監護人資料

Information on Parent / Guardian

姓名： (中)：

Name Chinese

(英)：

English

性別：

Sex

身份證號碼：

Identity Card No.

與申請人關係：

Relationship with Applicant

聯絡地址：

Contact Address

聯絡電話：(日)

Tel. No. Daytime

(夜)

Evening

3. 轉介醫生聲明

Declaration of the referring doctor

申請人所患疾病： Diagnosis of the Applicant:	
需要利妥昔單抗/生物仿製藥 *治療原因： Indications of Rituximab/biosimilar/ : (* please delete the inappropriate item) (Please ✓)	☐ Nephrotic Syndrome : ☐ Steroid Resistant / ☐ Steroid Dependent ☐ Refractory Lupus Nephritis ☐ Vasculitis resulting in Glomerulonephritis ☐ Others (Please specify) _____
以往曾用藥物： Previous drug(s) used: (Please ✓)	☐ Steroid ☐ Cyclosporine A ☐ MMF ☐ FK506/Tacrolimus ☐ Cyclophosphamide ☐ Rituximab ☐ Others (Please specify) _____

以前有否接受兒童腎病基金資助？

Whether the applicant has received subsidy from Children's Kidney Fund before?

☐ 有 Yes ☐ 沒有 No

如「有」，請填下表：

If yes, please fill in the following table --

以往接受本基金會贊助 利妥昔單抗/生物仿製藥 的紀錄： Previous applications of Rituximab /biosimilar subsidy approved by Children's Kidney Fund	申請日期： Date of application	1) _____	2) _____	3) _____	4) _____	5) _____
	總劑量： Total Dosage	_____ mg	_____ mg	_____ mg	_____ mg	_____ mg

茲証明上述申請人需接受利妥昔 /或其生物仿製藥 (*請刪除不適用者)，此次治療每次藥量為 _____ mg，共 _____ 次，推薦接受有關藥物費用資助。

This is to certify that the applicant needs to receive Rituximab (or Biosimilar) (* please delete the inappropriate item) treatment of _____ mg for _____ times for this course of treatment. I support this patient's application of drug subsidy according to the dosing suggestions above.

轉介醫生姓名：
Name of Referring Doctor

(中)

Chinese

(英)

English

簽署:

Signature

轉介日期:

Date of Referral

所屬醫院及地址：

Name of Hospital & Address

電話：

Tel. No.

4. 付款辦法

- ☐ 申請人先向醫院繳付費用，再提交醫院藥費收據正本，領取基金資助
Reimbursement on production of official receipts from the hospital
- ☐ 由基金向醫院直接繳付有關費用
The Fund to settle the cost directly with the hospital

5. 醫務社工審核

Assessment of Medical Social Worker

申請人家庭每月總收入（港幣）：

Total Family Income (HK\$)

家庭總收入與政府所訂「家庭住戶每月入息中位數」比例： % of Total Family Income at MMHDI

☐ 100%或以下
100% or below

☐ 100-130%之間
Between 100-130%

☐ 130%以上
Above 130%

醫務社工姓名：（中）

Name of MSW Chinese

（英）

English

簽署：

Signature

認可日期：

Date of Endorsement

所屬醫院：

Name of Hospital

聯絡地址：

Address

電話：

Tel. No.

6. 申請人聲明

Applicant's Declaration

茲証實上述資料無誤。

I declare that the above information is rightful and correct.

申請人(年齡十二歲以上者) 簽署：

Signature of Applicant (For age 12 or above)

父母 / 監護人簽署：

Signature of Parent / Guardian

收款人 (基金發放支票抬頭人) 姓名：

Name of Cheque Recipient

簽署式樣：

Specimen Signature

申請日期：

Date of Application

以下由基金工作人員填寫 (For Office Use Only)：

收件日期 : _____ 收件人簽署 : _____
Received Date _____ Signature of Receiving Officer _____

核准人簽署 : _____ 日期 : _____
Approved by _____ Date _____

檔案編號 : _____
Reference No. _____

備註 : _____
Remarks _____

附註 :
NOTES

1. 『利妥昔單抗(或其生物仿製藥)資助計劃』津貼，如病者家庭每月總收入於「家庭住戶每月入息中位數」百分之一百或以下，資助金額為藥物費用的百份之八十五。如家庭每月總收入介乎「家庭住戶每月入息中位數」百分之一百至一百三十之間，資助金額為購買藥物費用的百份之五十。

For patients with total family income 100% of the Median Monthly Domestic Household Income (MMDHI) or below, subsidy level of the Rituximab Treatment Subsidy is 85% of the drug cost. For those with total family income between 100-130% of MMDHI, the subsidy level is 50% of the drug cost.

2. 家庭每月總收入在「家庭住戶每月入息中位數」百分之一百三十以上，將不獲資助。

For patients with total family income above 130% of the Median Monthly Domestic Household Income (MMDHI), no subsidy would be approved.

3. 申請人年齡必須在 **21** 歲或以下，由醫院醫生推薦，並經醫務社工審核家庭收入。

The applicant's age must be 21 years or below, with recommendations from a hospital doctor and an assessment of family income by a medical social worker.

4. 每次申請的有效期為批核後的兩個月。

Each application is only valid for 2 months after it is approved.