Press Note

- In order to judiciously utilize the available stock of Liposomal Amphotericin B, Posaconazole and Isavuconazole, a system of online application for their allotment is being introduced.

- Application for these medicines should be sent in the enclosed proforma to the following email: ent-mcrm@telangana.gov.in

- The applications will be scrutinized by a committee consisting of DME, Superintendent of ENT Hospital and HoD of Department of ENT, Gandhi Medical College.

- Recommendation of the committee will be communicated to the approved applicant by email/SMS, indicating the name of the stockist from whom medicine can be purchased.

Application for liposomal Amphotericin B, Posaconazole and Isavuconazole

1. **Patient Details:**

S. No.	Information	Patient Details
1	Name	
2	Age	
3	Gender	
4	Body Weight	
5	Date of COVID positivity	
6	Date of Admission for COVID-19 treatment	
7	Hospital where treated for COVID-19	
8	Duration of hospital stay(Days)	
9	IP Number	
10	Name of attendant	
11	Mobile of attendant	
12	Email of attendant	

2. **Treating Hospital Details:**

S. No.	Information	Details
1	Hospital Name	
2	District	
3	Address	
4	Superintendent Name	
5	Superintendent Mobile	
6	Email address	

3. **Treating ENT/ Ophthalmic/ Neurosurgeon doctor:**

S. No.	Information	Details
1	Name	
2	Designation	
3	Mobile	
4	Registration number	

4. **History of mucormycosis Patient:**

S. No.	Information	Details
1	Duration of Symptoms	
2	Clinical features	
3	Endoscopy findings	
4	Any other treatment given	
5	Whether diabetic	
6	Weather oxygen therapy/ventilator therapy given	
7	Steroids given	
7a	If steroids given duration of steroid	
7b	Strength of Steroid given	

5. **Mandatory list of documents to be attached with application:**

S. No.	Information	Details
1	Photo of patient with lesion	
2	Picture of endoscopic findings	
3	KOH/ Culture Report	
4	Histopathology Report	
5	Imaging report	

6. Request for drug in order of preference

S. No.	Drug Request in order of preference
1	
2	
3	

Signed
(Superintendent of Hospital)
Name:
Designation:

Signed
(Treating ENT/Ophthalmologist/Neurosurgeon)
Name:
Designation:
Registration No:

Instructions:
Application in above format should be signed and emailed with attachments to ent_mcmr@telangana.gov.in