

**NON FORMULARY / NEW DRUG REQUEST FORM**

Patient name: Ward/Unit:

NHS number: Site:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | Consultant | | ………………………………………………………. | | | | | | |
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|  |  | |  | | | | | | |
| 2 | Drug: | |  | | | | | | |
|  | Approved Name/Strength/Form | | ………………………………………………………. | | | | | | |
|  |  | |  | | | | | | |
|  | Brand Name/Manufacturer | | ………………………………………………………. | | | | | | |
|  |  | |  | | | | | | |
|  | Class of Drug/BNF Group | | ………………………………………………………. | | | | | | |
|  |  |  | | | | | | | |
| 3 | Licensed indications and dosage (state NONE if not yet licensed) | | | | | | | | |
|  |  | | | | | | | | |
|  | ……………………………………………………………………………………………...……  ……………………………………………………………………………………………...…… | | | | | | | | |
|  | Any use outside licence or unlicensed dose intended | | | | | | | | |
|  |  | | | | | | | | |
|  | ……………………………………………………………………………………………...…… | | | | | | | | |
|  |  |  | | | | | | | |
| 4 | Previous relevant medication (doses, duration, effectiveness, tolerability, reasons for stopping) | | | | | | | | |
|  | ……………………………………………………………………………………………...……  ……………………………………………………………………………………………...……  ……………………………………………………………………………………………...……  ……………………………………………………………………………………………...……  ……………………………………………………………………………………………...……  ……………………………………………………………………………………………...…… | | | | | | | | |
| 5 | Advantages: |  | | | | | | | |
|  | Please state your reasons for wishing to use this product, any previous experience you have with it, and the advantage over present therapy. Include details of relevant clinical studies and supply copies of at least two of these studies with your application. | | | | | | | | |
|  | ……………………………………………………………………………………………...……  ……………………………………………………………………………………………...……  ……………………………………………………………………………………………...……  ……………………………………………………………………………………………...……  ……………………………………………………………………………………………...……  ……………………………………………………………………………………………...…… | | | | | | | | |
| 6 | Place in therapy/guidelines on patient selection (1st line, 2nd line, adjunctive) | | | | | | | | |
|  |  | | | | | | | | |
|  | ……………………………………………………………………………………………...…… | | | | | | | | |
|  |  | | | | | | | | |
| 7 | Please indicate if this is a substitution for an existing drug on the formulary | | | | | | | | |
|  |  | | | | | | | | |
|  | ……………………………………………………………………………………………...…… | | | | | | | | |
|  |  | | | | | | | | |
| 8 | Please indicate whether this request is likely to be for this patient only or if it is likely to be required for other patients | | | | | | | | |
|  |  | | | | | | | | |
|  | ……………………………………………………………………………………………...……  ……………………………………………………………………………………………...…… | | | | | | | | |
|  |  | | | | | | | | |
| 9 | GP Involvement | | | | | | | | |
|  | Will the GP be expected to prescribe | | | |  |  | Yes |  | No |
|  |  |  | | | | | | | |
|  | Does this raise shared care/funding issues | | | |  |  | Yes |  | No |
|  |  |  | | | | | | | |
|  | Have draft guidelines/protocols been produced  (If yes, please supply a copy) | | | |  |  | Yes |  | No |
|  |  |
|  |  |  | | | | | | | |
| If the request is for the addition of the drug onto the HPFT formulary as the intention is to use the medicine routinely as part of the treatment options, the requesting Consultant in conjunction with the Pharmacy team will be need to prepare a full evaluation of the drug requested based upon published literature. If you have any papers that may be pertinent to this evaluation, please send them with the application.  The Chief Pharmacist may circulate requests to other consultants in the Trust who may have an interest in the outcome of this request.  The Drugs and Therapeutics Committee meet 2 monthly you should allow eight weeks before a meeting date for preparation and distribution of an evaluation.  It is essential for the Consultant requesting the medicine to attend the meeting to support the application and answer questions. | | | | | | | | | |
| Consultant signature……………………………………………… Date ………………..  Declaration of interest in drug company ………………………………………………….. | | | | | | | | | |
| **Please return completed form to the Chief Pharmacist** | | | | | | | | | |
|  | | | | | | | | | |
| Date form requested | | | | …………………………………………………… | | | | | |
| Date form sent | | | | …………………………………………………… | | | | | |
| Date form returned | | | | …………………………………………………… | | | | | |
| Date application submitted to DTC | | | | …………………………………………………… | | | | | |
|  | | | |  | | | | | |
| Decision made by DTC | | | | **Approved / Not approved / Deferred** | | | | | |
|  | | | |  | | | | | |
| Guidelines prepared | | | | …………………………………………………… | | | | | |
|  | | | |  | | | | | |
| Funding available | | | | …………………………………………………… | | | | | |
|  | | | |  | | | | | |