

**NON-FORMULARY MEDICINE REQUEST FORM**

All sections of the form must be completed and submitted for approval before a prescription is issued unless delays in treatment would constitute a very significant clinical risk to individual patient care. Please note that non formulary medicines are unlikely to be prescribed by the GP and prescribing responsibility will remain with HPFT.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Part A. Patient Details** (**This field is compulsory**) | | | | | | | | | | |
| Name: Click here to enter text.  NHS Number: Click here to enter text.  Paris ID: Click here to enter text.  D.O.B: Click here to enter text. | | | | | | | | | | |
| **Part B. Medicine details** | | | | | | | | | | |
| Medicine name | | | | Click here to enter text. | | | | | | |
| Dose frequency and route of administration | | | | Click here to enter text. | | | | | | |
| Indication for medicines use | | | | Click here to enter text. | | | | | | |
| Duration of Treatment | | | | Click here to enter text. | | | | | | |
| Estimated annual cost per year (Check BNF) | | | | Click here to enter text. | | | | | | |
| Is this a licensed indication for the medicine? | | | | Yes  No (off-label) | | | | | | |
| Is this medicine licensed in the UK? | | | | Yes No  **Follow UMP** [**(Unlicensed Medicines Prescribing)**](https://hertfordshirenhs.interactgo.com/Interact/Pages/Content/Document.aspx?id=3814&SearchId=0) **Process** | | | | | | |
| Is the use of this medicine(s) for the indication being used recommended by NICE? | | | | Yes  No | | | | | | |
| If yes, please state which NICE guidance | | | | Click here to enter text. | | | | | | |
| Please clearly outline the published evidence supporting the use of this medicine for the indication being used **(please do not just add links to papers)**? | | | | Click here to enter text. | | | | | | |
| **Part C. Reason for Request** | | | | | | | | | | |
| Please outline the reason for this request and previous medicine(s), treatment, therapies tried | | | | | Click here to enter text. | | | | | |
| Please state the psychotropic medicines to be used in conjunction with the non-formulary medicine if approved. | | | | | Click here to enter text. | | | | | |
| **Part D. Monitoring of effectiveness of treatment with non-formulary medicine**  **(requesting clinician to complete)** | | | | | | | | | |
| What parameters or rating scale will be used to assess response to treatment? | | | Click here to enter text. | | | | | | |
| **Part E. GP involvement** | | | | | | | | | |
| Will the GP be expected to prescribe | Yes  No | | | | | | | | |
| Does this raise shared care/funding issues | Yes  No  Directorate | | | | | | | | |
| **Part F. Consultant Details** | | | | | | | | | |
| Consultant’s Name (PRINT) | | Click here to enter text. | | | | Service line or ward pharmacist | | Click here to enter text. | |
| Consultant’s Signature | | Click here to enter text. | | | | Date of request | | Click here to enter text. | |
| **Part G. DTC chair (or delegated deputy) authorisation of patient treatment for**  **requests to use non-formulary medicine.** | | | | | | | | | |
| **Approved:** Yes  Yes but review in 3 months  No | | | | | | | | | |
| Reason for  ‘not approved’ | Click here to enter text. | | | | | | | | |
| DTC chair’s name  (PRINT) | Click here to enter text. | | | | | | | | |
| DTC chair’s Signature | Click here to enter text. | | | | | | Date of outcome | | Click here to enter text. |

Please send completed form to [hpft.medsmanagement@nhs.net](mailto:hpft.medsmanagement@nhs.net)