

**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.

|  |
| --- |
| **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