This form is to be used for applications for new medicinal products, new formulations and extensions to previously agreed uses for medicinal and other relevant, pharmaceutical products to be prescribed by NHS services in the Northern Lincolnshire area.

Applications must include evidence-based information outlining the efficacy, therapeutic advantage, safety, financial impact and the cost relative to the products already used. Supporting documents should be from randomised controlled studies, NICE and professional, peer reviewed journals. Requests must be made by an appropriate clinician or other senior professional, for example a pharmaceutical advisor, dentist or optician.

Key points:

* Complete all sections. **Incomplete forms will not be processed.**
* The form should be completed electronically and submitted via email to the APC Professional Secretary.
* The application should be supported by the relevant clinical speciality groups and/or individuals as outlined in Section 2. All relevant groups and individuals from the organisation submitting this request must have commented on the request and dated the form before the APC will consider the application.
* An application for a drug that has been rejected within the last twelve months will normally be refused unless supported by new evidence or new licenced indications.
* The manufacturer (pharmaceutical company) may provide information supporting the application, but the application must originate from an appropriate professional.
* Where possible, electronic versions of any references and other supporting documents should be submitted electronically along with this form.
* Hospital clinicians are required to discuss their request and obtain support from their business/finance lead and other specialists within their department.
* If you have any problems or require further information, please telephone **Andy Karvot** on **03033 302127** or **07936 308862**.
* Do not submit patient identifiable data with this form.

APC Meetings are held on a monthly basis. Decisions regarding the addition of a new product to the Formulary will take place when feedback from the organisations involved (North Lincolnshire CCG, North East Lincolnshire CCG and Northern Lincolnshire and Goole NHS Foundation Trust) has been received. If the feedback is not received at least two weeks prior to the next APC meeting, the decision will be made at the subsequent meeting.

**Please submit by emailing this completed form and any supporting evidence to Northern Lincolnshire Interface Pharmacist, Andrew Karvot** [**a.karvot@nhs.net**](mailto:a.karvot@nhs.net)

**\*\*\* To select a check box, double click on the square and select the ‘checked’ option \*\*\***

**Please complete this form clearly and accurately. Avoid pasting lengthy documents into this form. Please attach relevant documentation together with this form or provide links to web references in Section 9.**

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| **1. APPLICANT DETAILS** | | |
| Name  Click here to enter text. | Position  Click here to enter text. | NHS Organisation  Click here to enter text. |
| Department (If Hospital) / Practice (If CCG)  Click here to enter text. | Email Address  Click here to enter text. | Telephone  Click here to enter text. |

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| **2. Compulsory Support from Department or Practice, Specialty Lead, Prescribing Lead, Organisation Group (e.g. M&T) and Business / Finance Officer**  This section must be completed fully before the APC will consider the Formulary Request. | | | |
| Name of supporting individual or group | Organisation | Comment | Date of Review |
| Click here to enter text.  Department or Practice  e.g. Dermatology or Medical Practice Name | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text.  Clinical Specialist  e.g. Consultant or GPSI (if applicable) | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text.  Group or Prescribing Lead  e.g. M&T or Named CCG Prescribing Lead | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text.  Business / Finance Official  e.g. Business Manager or Contracting Lead | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Area Prescribing Committee  Final Outcome | Northern Lincolnshire APC |  |  |

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| **3. DETAILS OF DRUG** | |  |  | |  |
| Non-proprietary name: | Click here to enter text. | | | Brand name: | Click here to enter text. |
| Dosage form and strength: | Click here to enter text. | | | | Tick if applies  Unlicensed Drug  Unlicensed Indication |

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| **4. INDICATIONS** | |
| Licensed indication for this medicine *(see SPC)*: | Click here to enter text. |
| Indication for which the medicine is requested | Click here to enter text. |

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| **5. REASON FOR REQUEST** | | |
| Tick one or more boxes | Therapeutic advantage over existing treatment    Cheaper than alternative treatment  Improved compliance | No alternative    New formulation    Other (please specify) |
| If there are advantages over existing medicines for the same indication(s), please state here. | Click here to enter text. | |

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| **6. ANTICIPATED PLACE IN THERAPY** |
| Please give a clear guideline including algorithms or flowcharts, indicating which group(s) of patients should and should notbe eligible to receive this medicine, including details of whether the drug is 1st line or not and the suggested criteria for selecting or not selecting the drug. Either explain below or attach a pathway. |
| Click here to enter text. |

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| **7. PRESCRIBING AND MONITORING** | |  | |  |
| Dosage regimen proposed for this application: | Dose and Frequency  Click here to enter text. | | Likely duration of treatment  Click here to enter text. | |
| Monitoring requirements (including criteria for stopping treatment) & implications for continued care: | Click here to enter text. | | | |
| Proposed formulary classification and any restrictions | Classification:  Red  Amber  Green  Other:  …………………. | | Prescriber restrictions  *(e.g. Consultant only. Etc)*  Click here to enter text. | |

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| **8. FINANCIAL ASPECTS** | | | |
| Please complete the following to allow likely usage and costs to be calculated. | | | |
| No of patients likely to be treated **per year** region wide | Average daily dose | Likely duration of treatment | Proportion of treatment likely to be supplied by the Hospital Trust |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| If you already have an estimate of the likely cost (to your directorate or CCG) of using this product, please give details below: | | | |
| **Estimated cost:**  If a business case has been prepared involving the use of this product please enclose details with this form | In next 12 months £ Click here to enter text.  Subsequent Years £ Click here to enter text. | | |
| Details of how estimated costs have been calculated | Click here to enter text. | | |
| Details of compensatory saving resulting from use of new product (please include details of possible savings in areas other than drugs expenditure) | Click here to enter text. | | |
| What is the likely impact of this product on primary care prescribing? | Click here to enter text. | | |

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| **9. SUPPLEMENTARY DETAILS** |
| Please give a concise outline of any additional information you would like to be considered along with this Formulary Request. This can include links to trial data, SIGN documents, NICE Guidance, SMC Guidance, Trial Data or any other relevant information. |
| Click here to enter text. |

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| **10. DECLARATION OF INTEREST** Members of the Area Prescribing Committee declare interests prior to discussing items relating to individual products. It is requested that applicants do the same. | | | | | |
| Details of any support or sponsorship (for staff, clinical trials, other research etc.) received or likely to be received from the manufacturer of this product within the last/next 12 months. If none, state ‘NONE’ | | | | | |
| Personal: | Click here to enter text. | Departmental: | Click here to enter text. |
| Applicant’s name:\* | Click here to enter text. | Date: | Click here to enter text. |
| \* By electronically submitting this form, you are confirming that you are the individual named above and that you have authority to use this system as set out in the terms and conditions. All applications will be scrutinised. | | | |