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| **Application form for the use of a new medicine or existing medicine for a new indication** |

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| **1. APPLICANT DETAILS** | | | |
| Name: | Trust/Organisation:  Specialty and Job Title: | | Email:  Contact Number: |
| **2. MEDICINE DETAILS** | | | |
| Name (generic and brand), Strength & Form: | | | |
| Dose: | | Intended duration of treatment: | |
| Licensed indication:  Intended indication for use: | | | |
| Starting criteria for the medicine:  Stopping criteria: | | | |
| **3. COMMISSIONING ROUTE FOR THE MEDICINE** | | | |
| Is the medicine excluded from the national tariff (PbR excluded)?  Yes  No  If yes: who is the responsible commissioner for the medicine?  CCGs  NHS England  If no: is the medicine part of a national specialised service?  Yes  No  Are services relating to this formulary application commissioned by local authorities (for example, alcohol misuse, smoking cessation, sexual health)?  Yes  No  \* If yes, please ensure you have documented (e.g. email) support from **all 6** SEL Local Authorities for this application\* | | | |
| **4. EVIDENCE TO SUPPORT APPLICATION** | | | |
| List below and append key supporting references: | | | |
| Outcomes anticipated from the medicine (include patient orientated outcomes as priority). | | | |
| Summarise any experience of using this medicine for the proposed indication (e.g. from local Trust approval for individual patients): | | | |
| **5. FORMULARY IMPLICATIONS** | | | |
| Detail below the proposed place in therapy and append a proposed treatment guideline: | | | |
| **6. COMPARISONS** | | | |
| Describe below how the medicine compares with existing treatment options: | | | |
| Indicate which medicine may be removed from the formulary if this is added: | | | |
| Comparative efficacy with existing formulary options: | | | |
| Comparative safety with existing formulary options: | | | |
| Advantages for the patient over existing therapies/interventions | | | |
| Cost comparison with existing treatment or standard of care/intervention:  Include costs across the whole health economy and your impression of the most appropriate prescriber (GP/Consultant/All) | | | |
| Hospital Activity Impact: Please provide detail on how addition of this medicine to the formulary will impact on:   * Outpatient appointments: * Follow up requirements e.g. monitoring: * Continued prescribing: * Day case attendances (e.g. to administer the medicine): * Inpatient stay:   What will the Primary Care Activity Impact be (in terms of continued prescribing and monitoring): | | | |
| **7. POPULATION SIZE** | | | |
| Specify number of patients with this condition per annum at your Trust and what percentage of these patients are from South East London:  Specify number of patients with this condition who would receive this drug per annum at your Trust:    Specify anticipated likely number of patients per annum per 100,000 of general population:  Where other Trusts in SEL wish to also have this medicine available for use, please specify patient numbers specifically for SEL population **at each Trust**: | | | |
| **8. RISK ASSESSMENT** | | | |
| *Detail below any potential risk issues that may arise with administration of this medicine. Please also suggest ways of reducing such risks:* | | | |
| **9. SHARED CARE ARRANGEMENTS** | | | |
| Is the medicine intended for GPs to continue care? Yes  No  If yes, after what time period should care be transferred to GPs?    If yes, a shared care protocol may necessary if agreed by the committee (please append examples if these are available): | | | |
| **10. CONSULTATION WITH COLLEAGUES AT OTHER TRUSTS IN SOUTH EAST LONDON (THE SUBMISSION WILL NOT BE ACCEPTED IF THIS SECTION HAS NOT BEEN COMPLETED)** | | | |
| Please tick the boxes below to ensure you have consulted with **all** Trusts in South East London:  Guy’s and ST. Thomas NHS Foundation Trust  Names of individuals consulted at GSTfT and summary of their opinions:  King’s College Hospital NHS Foundation Trust (Denmark Hill and PRUH sites)  Names of individuals consulted at KCH and summary of their opinions:  Lewisham and Greenwich Hospitals NHS Trust  Names of individuals consulted at LGT and summary of their opinions:  Oxleas NHS Foundation Trust  Names of individuals consulted at Oxleas and summary of their opinions:  South London and Maudsley Hospital NHS Foundation Trust  Names of individuals consulted at SLaM and summary of their opinions:  Where the drug is commissioned through Local Authorities (LA), please provide email confirmation to your formulary pharmacist from each SEL LA representative that this submission is supported by the LA. | | | |
| **11. CONFLICTS OF INTEREST** | | | |
| As part of the application process, all applicants are required to complete the attached Declaration of Interest form (DoI). Formulary submission forms will **not** be accepted without a completed DoI form. The DoI form will be provided to you with the application form by your Trust formulary/CCG lead pharmacist. Please contact your Trust formulary/CCG lead pharmacist if you have not been provided with the DoI form. | | | |
| **12. DECLARATION** | | | |
| This submission form has been completed by a clinician(s) and not by a pharmaceutical industry representative:  This submission has been discussed with and is agreed by the Clinical Director/Prescribing Lead: | | | |

**Final Checklist:**

* Application form **fully** completed
* Supporting documents to append:

References

Treatment Protocol/Guideline

Signature of requesting Consultant/GP...............................................

Print Name........................................................... Date............................

Signature of Clinical Director/GP CCG Board Lead.......................................

Print Name............................................................ Date.............................

Division......................................................

Signature of Service General Manager.......................................

Print Name............................................................ Date.............................

Division......................................................

**PLEASE EMAIL ANY QUERIES, COMPLETED FORMS AND SUPPORTING DOCUMENTS TO:**

[**gst-tr.selondonformulary@nhs.net**](mailto:gst-tr.selondonformulary@nhs.net)

**NOTE:** Electronically sent forms are acceptable, where email approval from the appropriate clinical director and service manager has been received

**\*\*\*INCOMPLETE FORMS WILL NOT BE ACCEPTED AND WILL BE RETURNED TO THE REQUESTING CONSULTANT\*\*\*\*\***