

## APPLICATION TO INCLUDE A MEDICINE IN THE NORTH AND SOUTH STAFFORDSHIRE JOINT FORMULARY

### SECTION 1 - TO BE COMPLETED BY THE REQUESTING CONSULTANT OR G.P.

**APPROVED DRUG NAME,  
STRENGTH AND FORM**

**TRADE NAME AND  
MANUFACTURER**

**PROPOSED INDICATIONS**

IS THE DRUG LICENSED IN THE U.K?

Yes  No

IS THE PROPOSED INDICATION A LICENSED INDICATION FOR THE DRUG?

Yes  No

**IF THE ANSWER IS 'NO' TO EITHER OF THE ABOVE QUESTIONS  
PLEASE COMPLETE THE UNLICENSED MEDICINES FORM AND INCLUDE WITH YOUR APPLICATION**

WILL THE DRUG REPLACE AN EXISTING DRUG ON THE FORMULARY?

Yes  No

IF YES, WHICH DRUG?

ESTIMATED NO. OF PATIENTS TO BE PRESCRIBED NEW DRUG

EXPECTED FINAL DOSE RANGE

DURATION OF TREATMENT i.e. long term or acute course

ESTIMATED ANNUAL COST OF NEW DRUG PER PATIENT

£

THE COST OF THIS DRUG CAN BE MET BY REDUCING EXPENDITURE ON:

WHO DO YOU PROPOSE SHOULD PRESCRIBE THE DRUG?

- 1. Hospital and Primary Care Prescribers
- 2. Hospital Doctors and G.P.s in Primary Care
- 3. Initiation only within Hospital by:
  - Hospital Prescribers
  - Hospital Doctors
  - Hospital Consultants
  - Hospital Consultants with a specialist interest
- 4. Initiation only within Primary Care by:
  - Primary Care Prescribers
  - G.P.s
- 5. Initiation in Hospital and managed according to a shared care protocol
- 6. Initiated and managed within the Hospital
- 7. Other, please explain

**SECTION 2 - EVIDENCE TO SUPPORT YOUR APPLICATION TO BE COMPLETED BY THE REQUESTING CONSULTANT OR G.P.**

INDICATE THE BENEFITS OF THE PROPOSED DRUG FROM THE LIST BELOW:

1. Reduction in mortality
2. Reduction in morbidity/improved quality of life
3. Improved safety
4. Improvement in surrogate marker, e.g. tumour site
5. Improved tolerability
6. Conveniently administered
7. Saving in non-drug costs, e.g. length of hospital stay, when alternative is surgery
8. Saving in drug costs

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PLEASE GIVE A BRIEF SUMMARY OF PUBLISHED EVIDENCE TO SUPPORT YOUR APPLICATION AND ANY PREVIOUS CLINICAL EXPERIENCES WITH THE PROPOSED DRUG

PLEASE EXPLAIN THE ADVANTAGES OF THE PROPOSED DRUG OVER EXISTING FORMULARY AGENTS

PLEASE LIST ANY DISADVANTAGES OF THE PROPOSED ADDITION

PLEASE QUOTE 2 REFERENCES TO COMPARATIVE TRIALS OF THE DRUG IN SUPPORT OF YOUR APPLICATION

REFERENCE 1

AUTHORS	
TITLE	
JOURNAL	
ISSUE NO./ VOLUME/YEAR	

REFERENCE 2

AUTHORS	
TITLE	
JOURNAL	
ISSUE NO./ VOLUME/YEAR	

PLEASE SUPPLY A COPY OF EACH OF THE ABOVE REFERENCES

REQUESTING CONSULTANT OR  
G.P. (NAME IN BLOCK CAPITALS)

CONTACT ADDRESS AND  
TELEPHONE NUMBER

E-MAIL ADDRESS

SIGNATURE

DATE

**SECTION 3 - TO BE COMPLETED BY CLINICAL DIRECTORS (SECONDARY CARE) ONLY**

1. I support this Formulary Application
2. I do not support this Formulary Application

PLEASE EXPLAIN THE REASONS FOR YOUR ANSWER

CLINICAL DIRECTOR

SIGNATURE

DATE

**SECTION 4 - TO BE COMPLETED BY PCT PHARMACEUTICAL ADVISORS (PRIMARY CARE ONLY)**

- I have read this application and;
- I agree that this application should be reviewed by the New Medicines Committee
- I do not feel that this application is appropriate for review by the New Medicines Committee

PLEASE EXPLAIN THE REASONS FOR YOUR ANSWER

NAME

SIGNATURE

DATE

**Return completed form to Mohammed Azar, Deputy Director of Pharmacy and Medicines Optimisation,  
Pharmacy and Medicines Optimisation,  
Midlands Partnership NHS Foundation Trust, St Chads House,  
St Georges Hospital, Corporation Street, Stafford, ST16 3AG**