Staffordshire Health Economy

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	☐

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 Denis Kanu, Staffordshire and Stoke-On-Trent CCGs Interface Pharmacist, Medicines Commissioning Team, Smithfield One Building, Leonard Coates Way, Hanley, Stoke-on-Trent, ST1 4FA or via email to medopsqueries@stoke.nhs.uk