**Non-Formulary Medicine/Wound Product Request Form**

**(including off-label/unlicensed use)**

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| **Please complete this form, including authorised signatures and send to:**  **Medicines** [BOR.Prescribing@borders.scot.nhs.uk](mailto:BOR.Prescribing@borders.scot.nhs.uk)Medicines application will be submitted to NHS Borders Non Formulary Review Panel for review; unless the request is clinically urgent and for response within 7 days.  **Wound Products** [cheryl.lugton@borders.scot.nhs.uk](mailto:cheryl.lugton@borders.scot.nhs.uk). **Wound formulary products will only be approved for a three-month period and a new application will be required to continue the treatment**  **Decision will be shared with Prescriber, Peer Support & Practice Manager after meeting**  **All fields below are required to be completed for application to be considered** | |
| **1. Patient CHI Number:** | (Please do not include patient name and address for this individual application) |
| **Patient GP Practice:** | **Ward / Clinic Details** (if appropriate): |
| **2. Diagnosis/indication for use:** | |
| **3. Medicine/dressing Details:**  Name……………………………………………………Dose..........................................…………..  Duration of treatment/no of cycles………………………………………..………………………………….  Estimated annual cost per patient/year…………………………………………………………………….  Licensed indication/ unlicensed indication?................................................. | |
| **4. Reason for Request**  Previous therapy……………………………………………………………………………………………..  Reason NF medication requested…………………………………………………………………………  If request is urgent, (for response within 7 days) include reason for urgency ……………………………………………………………………………………………………………………..  *Non-urgent requests will be reviewed by NHS Borders NF review panel (within 4 weeks)* | |
| **5. Duration of Treatment -** Please indicate if this is a request for:  - on-going prescribing of a currently prescribed non-formulary medicine  - new initiation of a non-formulary medicine  - expected duration of treatment…………………………………………………………………………… | |
| **6. Supporting evidence of clinical benefit (minimum 1 reference)** | |
| **7. Supporting Prescriber details**  Prescriber Name (print)…………………………….Signature………………………..Date…………...... | |
| **8. Peer Support Information**  GP/Prescriber/Consultant/Specialist Name  (print)……………………………..............................Signature………………………..Date………….......  Clinical director………………………….…………..Signature………………………...Date……………… | |
| **9. Declaration of Interest YES / NO** (please circle)  Please detail if Yes …………………………………………………………………………………………… | |
| **10. Date of Meeting / Approved for Use**  Committee/Chair………………………..…...Date……………… | |