**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.ukMedicines 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. **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……………… |