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Description automatically generatedNHS BORDERS NON-FORMULARY MEDICINE REQUEST FORM**

All sections of the form must be completed before a non-formulary medicine can be dispensed by Pharmacy unless delays in treatment would constitute a very significant clinical risk to individual patient care. This form relates **to new treatment** in a patient. If the NFR application is approved for a set period of time, to continue long term treatment a new form is required.

**Non-formulary medicines include:**

* Medicines recommended by SMC, but an application has not yet been made to the East Region Formulary.
* Medicines recommended by SMC but following consideration by the East Region Formulary are **‘not routinely available’**.
* Unlicensed medicines prescribed for individual named patients. For unlicensed medicines also refer to the policy – “Accessing drugs that are not on the ERF”.
* For medicines which have been assessed by SMC and “not recommended for use in Scotland” a PACS Tier 2 form is required.

**Parts G1 and G2 require to be completed for requests to use high-cost medicines.**

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| **Part A. Patient Details** (Attach label if available) | | | | | | | | | | | | | | | | |
| Name:  Address:  CHI Number:  Weight (Kg): | | | | | | | | | Indication for use of medicine: | | | | | | | |
| Hospital/Ward/Clinic: | | | | | | | | | Patients home Health Board: | | | | | | | |
| GP practice: | | | | | | | |
| **Part B. Medicine details** | | | | | | | | | | | | | | | | |
| Medicine name | | | | | |  | | | | | | | | | | |
| Dose frequency and route of administration | | | | | |  | | | | | | | | | | |
| Duration of Treatment/No. of cycles | | | | | |  | | | | | | | | | | |
| Estimated annual cost per patient year | | | | | |  | | | | | | | | | | |
| Is this a licensed medicine for this indication | | | | | | Yes  No (off-label) | | | | | | | | | | |
| Is this an unlicensed medicine | | | | | | Yes  **Additional paperwork required** | | | | | | | | | | |
| SMC Approved for this indication | | | | | | Yes  No  refer to PACS Tier 2 paperwork | | | | | | | | | | |
| Requested type of prescribing | | | | | | General | | | | Specialist Initiation | | | | | | Specialist Use Only |
| **Part C. Reason for Request** | | | | | | | | | | | | | | | | |
| Previous systemic therapy used to treat condition to date (include response and duration if possible.) | | | | |  | | | | | | | | | | | |
| Reason for this request *(include urgency – routine (up to 4 weeks response time) or clinically urgent (up to 3 days response time)* | | | | |  | | | | | | | | | | | |
| For off-label requests - submit evidence to support the treatment request, including safety and effectiveness data | | | | | Additional evidence attached:  Yes  No | | | | | | | | | | | |
| **Part D. Monitoring of effectiveness of treatment with non-formulary medicine**  **(requesting clinician to complete)** | | | | | | | | | | | | | | | |
| Treatment parameters to be assessed  (Clinical response, biochemical markers, etc.) | | | | | | |  | | | | | | | | |
| Side effects to be monitored | | | | | | |  | | | | | | | | |
| Exit strategy summary | | | | | | |  | | | | | | | | |
| **Part E. Consultant Details** | | | | | | | | | | | | | | | |
| Consultant’s Name (PRINT) | | |  | | | | | | | | Directorate | | |  | |
| Consultant’s Signature | | |  | | | | | | | | Date | | |  | |
| **Part F. Clinical Pharmacist** | | | | | | | | | | | | | | | |
| Comments | | |  | | | | | | | | | | | | |
| Clinical Pharmacist Name (PRINT) | | |  | | | | | | | | Date | | |  | |
| Clinical Pharmacist Signature | | |  | | | | | | | | | | | | |
| **Part G1. Clinical Director (or delegated deputy) authorisation of patient treatment costs for**  **requests to use high-cost non-formulary medicine.** | | | | | | | | | | | | | | | |
| **Outcome of request: (please circle/highlight): APPROVED / NOT APPROVED – document reason below** | | | | | | | | | | | | | | | |
| Reason for  ‘not approved’ outcome: | |  | | | | | | | | | | | | | |
| Clinical Director’s Name (PRINT) | |  | | | | | | | | Directorate | |  | | | |
| Clinical Director’s Signature | |  | | | | | | | | Date | |  | | | |
| **Part G2. Budget Holder authorisation of patient treatment costs for requests to use high cost**  **non-formulary medicines.**  **Signing the request is confirmation that budget is available to fund the treatment.** | | | | | | | | | | | | | | | |
| **Outcome of request: (please circle/highlight): APPROVED / NOT APPROVED – document reason below** | | | | | | | | | | | | | | | |
| Reason for  ‘not approved’ outcome: | |  | | | | | | | | | | | | | |
| Budget Holder’s Name (PRINT) | |  | | | | | | | | Directorate | |  | | | |
| Budget Holder’s Signature | |  | | | | | | | | Date | |  | | | |
| **Part H. Non-Formulary Panel** | | | | | | | | | | | | | | | |
| **Outcome of request (please circle/highlight):**  **APPROVED / NOT APPROVED / MORE INFORMATION REQUIRED** | | | | | | | | | | | | | | | |
| **Type of prescribing:** | **General** | | | | | **Specialist Initiation** | | | | | | | **Specialist Use Only** | | |
| NFR committee chair to list monitoring requirements, exit strategy or reasons for non-approval | | | | | |  | | | | | | | | | |

Trends in non-formulary medicine requests will be reported to the NHS Borders Area Drugs and Therapeutics Committee and Medicines Resource Group to highlight any necessary formulary committee submissions.

**A copy of the completed form should be sent immediately to** [**BOR.Prescribing@borders.scot.nhs.uk**](mailto:BOR.Prescribing@borders.scot.nhs.uk)