**Proforma for Cariprazine Requests**

This form **must** be completed by a Consultant Psychiatrist and submitted to **both** the Chief Pharmacist and Deputy Chief Medical Officer for approval via the generic inbox for medicines approvals medicine.approvals@lscft.nhs.uk

# Introduction

* Cariprazine is approved for use in Lancashire and South Cumbria as second line treatment in patients with persistent negative symptoms of schizophrenia.
* It will not be approved for any patients meeting the criteria for treatment resistant schizophrenia unless the use of clozapine is contraindicated e.g. previous red result, cardiomyopathy or myocarditis, or where the patient is adamantly refusing clozapine despite repeated interventions to overcome refusal.
* It will not be approved for women of child bearing potential unless highly effective contraception is being used and women prescribed a systemically acting hormonal contraceptive agree to use of a second barrier method of contraception.
* It will not be approved for off-label use.

# Request Form

|  |  |
| --- | --- |
| Patient Name:  |   |
| NHS Number:  |   |
| Date of Birth:  |   |
| Diagnosis:  |   |
| Inpatient ward/community team:  |   |
| Consultant:  |   |

1. **Does the patient meet criteria for treatment resistant schizophrenia?**

|  |  |  |
| --- | --- | --- |
|   | No  |   |

Yes

If yes, outline reasons why clozapine is not considered clinically appropriate

|  |
| --- |
|   |

1. **Is the patient a woman of child-bearing potential?**

|  |  |  |
| --- | --- | --- |
|   | No  |   |

Yes

If yes, please outline the form of contraception currently used

|  |
| --- |
|   |

1. **Medication History**

Please include the following information about all prescribed antipsychotic medication:

• Drug, maximum prescribed dose, duration of treatment, response to treatment (positive and negative symptoms), adverse effects.

|  |
| --- |
|   |

1. **Negative Symptoms**

Please outline in detail current negative symptoms and the associated psychosocial impact.

|  |
| --- |
|   |

1. **Consent to Treatment**

Patient has capacity and is consenting to treatment

|  |
| --- |
|   |
|   |

Patient lacks capacity and treatment will be administered under the Mental Health Act

**Should this request be approved, I confirm I will ensure any women of child bearing potential are informed of the need to continue highly effective contraception whilst Cariprazine is prescribed and for 10 weeks after treatment stops. Where systemically acting hormonal contraceptives are used I will inform the patient of the need to use a second barrier method of contraception. I will document the provision of this information in the clinical record.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Consultant’s signature**  |   | **Date**  |   |
| **Print name**  |   |   |

 **Outcome**

|  |  |
| --- | --- |
|   |   |
|   |

Request

Approved

Request Not

Approved:

Reason

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed**  **(Chief**  **Pharmacist):**  |   | **Date**  |   |
| **Signed** **(Deputy Chief** **Medical Officer):**  |   | **Date**  |   |