**New Medicines Request Form**

**Available at** [**https://www.lancsmmg.nhs.uk/about-us/downloads/forms/**](https://www.lancsmmg.nhs.uk/about-us/downloads/forms/)

**Please complete electronically, ensuring all sections are completed. Any missing information will require the form to be returned for amendment and may delay the application**

**Return completed forms to:** **mlcsu.lscformulary@nhs.net**

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| 1. **Medicine Details**
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| 1a. Approved Name (generic, brand if relevant): |
| 1b. Form and strength: |
| 1c. Proposed intended indication:  Please indicate the licensing status:* Licensed drug for licensed indication
* Licensed drug for ‘off label’ indication
* Unlicensed drug
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| 1d. Anticipated duration of treatment |
| 1e. Is there a NICE technology appraisal or NICE Guidance for this drug and indication? If yes please state number: |

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| 1. **Formulary Implications**
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| 2a. Place in therapy – indicate below (Please include separate algorithm / treatment protocol as appropriate.) |
| First line | Second line | Replacing another product  | Other |
| 2b. Introduction on to formularyPatient group:Specific directorate / consultants (if RED indication): Any prescribing restrictions:Is prescribing in primary care is envisaged? YES / NOIf YES, do you think shared care or prescribing support guidance is required (give details): |
| 2c. How will this medication change the use of other medicines or treatments? (Please indicate whether this medicine would be used in addition to or instead of others in the treatment pathway. Will it replace an existing medicine in a pathway?) |

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| **3. Supporting Evidence (This section is NOT required if the medication has a NICE TA or NICE Guidance)** |
| 3a. What evidence is there of the effectiveness for this medication for the specified indication? (Please include details of the principal trials and the results regarding outcomes (e.g. absolute or relative risk reduction or NNT) and efficacy. Please include links where appropriate) |
| 3b. What are the advantages of this medication compared to the current formulary treatment for the specified indication? (Consider efficacy, safety and ongoing monitoring requirements. If long-term monitoring requirements, please detail who would be expected to perform these e.g. acute trust / primary care) |
| 3c. What is the available evidence on the cost–effectiveness and patient outcomes of this medication? (consider cost effectiveness compared to current treatments, effects on a patient’s quality of life)Please reference your evidence for cost-effectiveness and patient outcomes and include electronic copies of key supporting documents. |

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| **4. Risk Assessment & Management** |
| What are the risks of introducing the medication onto the formulary and how will these be addressed? This should include how the introduction of this drug/preparation may affect any local or regional guidance or effect other speciality(If RED indication it is expected the clinician making the application will take ownership in managing the safe introduction of the drug into practice. Please include copies of evidence based guidelines developed to support the introduction, and detail staff education / training that will be put in place or guidelines that will need to be developed or updated to reflect change in practice.) |

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| **5. Patient Experience** |
| How will the medication impact on the patient experience?(Consider quality of life, adverse effects, improved compliance, reduction in hospital admissions/attendance, care closer to home etc) |

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| **6. Commissioning Arrangements** **(Seek advice from pharmacy if clarification required)** |
| Is the medication PBR excluded?  |  Yes / No |
| Who is responsible for commissioning the medication/service? |
| PbR excluded/ICB | NHS England | Cancer Drugs Fund | Tariff |

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| **7. Financial Implications** |
|  | **Primary care** | **Secondary care** |
| Cost per patient of **current** treatment per year? (If the full course of treatment is less than one year, please indicate this and give the cost of the course) |  |  |
| Cost per patient of **new** treatment per year?(If the full course of treatment is less than one year, please indicate this and give the cost of the course) |  |  |
| Change in cost per patient per year? |  |  |
| Anticipated number of patients per year(Please indicate if this is total number for your organisation or the total across Lancashire and South Cumbria) |  |  |
| Anticipated financial impact to Trust or ICB per year |  |  |
| Will introduction of this medication alter the patient pathway?(Specify any other additional costs or cost savings as a result of switching. Consider changes in monitoring requirements, change in income from alteration in activity, cost savings by reducing number of bed days, avoidance of surgical procedures, change in equipment etc. Also consider guidance that will change if this drug/preparation is introduced) |  |

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| **8. Continuing Care Arrangements (Including Proposed RAG (traffic light) status) Please tick:** |
| SHORT term secondary care only (RAG rating RED)No prescribing in primary care required. |  |
| LONG term secondary care (RAG rating RED)Prescribing will need to remain in secondary care: | Please state reason: |
| Primary care (RAG rating Green)Prescribing can be initiated and maintained in either primary or secondary care. |  |
| Primary care (RAG rating Amber 0)* Suitable for prescribing in primary care following recommendation or initiation by a specialist.
* Little or no specific monitoring required.
* Patient may need a regular review, but this would not exceed that required for other medicines routinely prescribed in primary care.
 | Brief prescribing document or information sheet may be required: |
| Amber 1 – with shared care* Suitable for prescribing in primary care following recommendation or initiation by a specialist.
* Minimal monitoring required.
* Patient may need a regular review, but this would not exceed that required for other medicines routinely prescribed in primary care.
* Full prior agreement about patient’s on-going care must be reached under the shared care agreement.
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| Amber 2 – with shared care and enhanced service* Initiated by specialist and transferred to primary care following a successful initiation period.
* Significant monitoring required on an on-going basis.
* Full prior agreement about patient’s on-going care must be reached under the shared care agreement.
* Suitable for enhanced service (subject to local commissioning).
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| For further details regarding RAG rating please see: <https://www.lancsmmg.nhs.uk/about-us/colour-classification/>  |  |

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| **10. Conflict of Interest** |
| Applicants are required to declare any potential competing interests:  |
| Have you (or your partner/other close relative) received payment or other support from a company? For example consultancies, fee-paid work, travel grant or pharmaceutical company shares.  | YES / NO |
| Has your unit or place of work received support from a company?For example funding a nurse, building or piece of equipment | YES / NO |
| If you have answered yes to either of the above questions – please add further details below: (The amount of monetary value involved does not have to be declared) |
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| **11. Signatures** |
| Signatures supporting request for addition of a medication to the Lancashire and South Cumbria Integrated Care Board FormularyThe application will only be considered if the signature section is fully completed. By approving the application the Clinical Director/Directorate General Manager undertake that any financial implication of use of the new drug will be met within existing resources, or that additional financial resource has been secured for the purpose. |
| Application for: |

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| **Requesting and supporting Clinicians** |
| Name | Post | Signature | Date |
| Name | Post | Signature | Date |
| Name | Post | Signature | Date |

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| Supporting Lead Divisional Pharmacist (applications from secondary care) |
| Name | Post | Signature | Date |

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| Approval from local Medicines committee (applications from secondary care) |
| Committee name: | Date |

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| **Trust Authorisation (BTH, ELHT, LSCFT, LTHTR, UHMB)**  |
| Clinical Director |
| Name | Signature | Date |
| Directorate / Care Group General Manager |
| Name | Signature | Date |

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| **Primary Care Authorisation (for drugs/preparations likely to be classified as Amber/Green)** |
| Name | Signature | Date |
| **For Medicines Management Committee use and completion only** |
| Outcome: | Follow up: |