# Prescribing Request to Primary Care for Unlicensed Medicine

NHS Lanarkshire

Dear Dr _____ Date _____

| Patient | | CHI no. |
|---|---|---|

**I would be obliged if you would prescribe the following for this patient**

| Medicine | Form |
|---|---|
| Dose | Frequency |
| Indication | |

**This request falls under the following GMC reason for prescribing an unlicensed medicine** ***(please tick)***

| **THERE IS NO SUITABLY LICENSED MEDICINE THAT WILL MEET THE PATIENT'S NEED** | |
|---|---|
| i. Medicine is not licensed for the specific age of the patient but is licensed for the indication in other age groups | |
| ii. Medicine is not licensed for the specific age and for the specific indication but is licensed for other indications in that age group and for the indication in other age groups | |
| iii. The licensed dosage would not meet the patient's needs | |
| iv. The patient requires a formulation that is not available as a licensed product | |
| v. Other (*specify*) | |

| **A SUITABLY LICENSED MEDICINE THAT WOULD MEET THE PATIENT'S NEED IS NOT AVAILABLE** | |
|---|---|
| i. Temporary shortage of licensed medicine | |
| ii. No licensed formulation available in UK but is available for import from abroad | |
| iii. Medicine is at pre-marketing authorisation stage or has been discontinued and can be used for a named patient on compassionate grounds | |
| vi. Other (*specify*) | |

| **PRESCRIBING FORMS PART OF A PROPERLY APPROVED RESEARCH PROJECT** | |
|---|---|

**Evidence for use of medicine**

| |
|---|
| The unlicensed / off-label use of this medicine is described as an evidence based treatment option within established guidelines referenced below. ☐<br><br>*Quote Guideline(s) e.g. SIGN, NICE, BNF, The Maudsley Prescribing Guidelines in Psychiatry, Scottish Palliative Care Guidelines, British Association of Dermatologists.* |
| Treatment is not described in established guidelines but approval from the relevant body (e.g. clinical director, ADTC) has been obtained in this instance. ☐<br><br>*Quote approval body and references to relevant primary work* |

| **I consider this treatment necessary for the following reasons** |
|---|
| |

**Monitoring Arrangements**

| Requirements | Who will take responsibility for monitoring & where | Frequency |
|---|---|---|

| Initial duration of medication trial | Treatment review date |
|---|---|

| Special precautions (*if any*) |
|---|

I have explained to the patient/patient representative that this treatment is unlicensed and the reasons for this and have attached a signed copy of consent (*see overleaf*).

Signature _____ Name _____ Job title _____

*A copy of this form should be retained in the patient notes, a copy should be sent to the patient's GP and if requested a copy should be given to pharmacy (hospital or community).*

ADTC ratified: March 2019

# Patient Consent to Unlicensed Medicine Use

I am aware that Dr _____ has recommended treatment with

_____ (*name of medicine*)

It has been explained that this medicine is not licensed (*tick as appropriate*)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| for use in the UK | | for the condition I am being treated for | | at the dose prescribed | | in this age group | |

Alternative treatments have been discussed, the potential risks and benefits have been explained and I have been given information about this medicine.

I agree to this medicine being prescribed and understand I can withdraw my consent at any time.

☐ I am the patient

☐ I am the representative of _____ (*name of patient*)

*Parent / guardian of child / welfare power of attorney / welfare guardian for AWI (delete as appropriate)*

Patient / Representative Name _____

Patient / Representative Signature _____ Date _____

---

This patient is being treated under Section 47 of the Adults with Incapacity Act and has no welfare guardian or welfare power of attorney to consent on their behalf. A Section 47 certificate of incapacity has been completed.

Name _____ Job Title _____

Signature _____

Name of RMO _____

*A copy of this form should be retained in the patient notes, a copy should be sent to the patient's GP and if requested a copy should be given to pharmacy (hospital or community).*

ADTC ratified: March 2019