# Non-Formulary Medicine/Wound Product Request Form
# (including off-label/unlicensed use)

**Please complete this form, including authorised signatures and send:-**
**Medicines** liz.leitch@borders.scot.nhs.uk **Wound Products** cheryl.lugton@borders.scot.nhs.uk
The application will be submitted to NHS Borders Formulary Committee; Area Drug and Therapeutic Committee; or Wound Formulary Group for a decision unless a delay would constitute a significant clinical risk to the patient; if an urgent response is required, a decision will be reached electronically by Formulary Committee members & the response communicated to the applicant within 7 days of the formulary pharmacist receiving the completed application form from the applicant. **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 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. Drug Details:**

Drug Name……Dose.....……..

Duration of treatment/no of cycles……..……..

Estimated annual cost per patient/year……..

**4. Reason for Request**

Previous therapy……..

Reason NF medication requested……

Please state if request is urgent, including reason for urgency – response required within 7 days.
*Non-urgent requests will be submitted to NHS Borders FC or ADTC for a decision within 4 weeks*
*Non urgent requests for wound products to be submitted to NHS Borders Wound Formulary Group.*

**5. On-going Treatment -** Please indicate if this treatment is on-going prescribing and please give all relevant details:

**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……