**SECTION 1 - Introduction**

* The Lanarkshire Joint Adult Formulary aims to promote safe, effective and economic prescribing in both Primary and Secondary care.
* The Formulary Amendment Request Form should be used for any additions, deletions or substitutions and must have the support of both a clinician and a specialist pharmacist from either Primary or Secondary care, depending on where the medicine will most likely be used. In the absence of a specialist pharmacist, a Primary Care Lead Pharmacist or Head of Pharmacy would be acceptable.
* Please complete the form as fully as possible to avoid delays. Return the form to the Medicines Policy & Guidance Team by email **(**[**medsguidance@lanarkshire.scot.nhs.uk**](mailto:medsguidance@lanarkshire.scot.nhs.uk)**)** who may ask for more information if required.
* All requests will be reviewed and approved by the Lanarkshire Area Drug and Therapeutics Committee, and the applicant informed of the final decision.

Medicines and non-medicines within the NHS Lanarkshire Joint Adult Formulary are categorized as either:

**Preferred list (P)**: First-line formulary choices.

**Total list (T)**: Alternative choices when preferred list options not effective/not tolerated, or not indicated.

**Specialist initiation (S1)**: Specialist initiation, or on the advice of a Consultant or Specialist Practitioner in this therapeutic area. Continuation in primary care is acceptable.

**Specialist use only (S2)**: Supply via hospital, Homecare Service or a hospital based prescription (HBP) for dispensing by community pharmacy. Not prescribed in primary care setting.

**SECTION 2 - Summary of Medicine/Item**

|  |  |
| --- | --- |
| **Medicine/Item name** |  |
| **Indication** |  |
| **Formulation** |  |
| **Route of Administration** |  |
| **Is the medicine/non-medicine licensed for this indication? \* (Y/N)** |  |
| **Is the indication in line with SMC advice, if applicable? \* (Y/N/Not applicable)** |  |
| **Has a clinical protocol or guideline been developed?**  **(Y/N) If yes, please attach a copy** |  |

*\*Please note there is a separate process for prescribing unlicensed medicines; please refer to the below flowchart for guidance*:<https://nhslguidelines.scot.nhs.uk/media/1445/flowchart-which-form-do-i-need-to-complete.pdf>

If the medicine is licensed, but not SMC approved – please follow the flowchart for guidance

**SECTION 3-Details of Change Requested**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  | | --- | --- | --- | | **Amendment type:** | | | | **Addition** | **Removal** | **Substitution** | | **Please provide further details** | | | | | | |
| **Should patients prescribed the current product be considered for review? If Yes, please indicate which status is most applicable** | | | **(Yes/No/Not Applicable)** |
| **Specialist review of individual patients required to review treatment** | **Specialist input is required to lead a review program** | **No specialist input required, general practice can review as part of routine patient review** | |
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| **Proposed formulary category: tick appropriate box (see above for details of category)** | | | | | |
| **PREFERRED LIST (P)** | **TOTAL LIST** **(T)** | | **SPECIALIST 1 (S1)** | **SPECIALIST 2 (S2)** | |
| **Please indicate the likely number of patients who may be treated per year in NHS Lanarkshire** | | | | | |
|  | | | | | |
| **What are the cost implications of this change?** | | | | | |
|  | | | | | |
| **Will there be any effect on service provision associated with the introduction of this product e.g. impact on nursing/medical/pharmacy duties, impact on Primary Care, or laboratory/ imaging services?** | | | | | |
|  | | | | | |
| **Are there any monitoring requirements? If yes, please list further details below.** | | | | |
| **Primary Care** | | **Secondary Care** | | |

**SECTION 4-Declaration of Interests**

**Please declare any relevant interests that you (clinician and supporting pharmacist) have in respect to this application (e.g. company shares, sponsorship/financial support/departmental support received etc.)**

**To be able to validate the electronic signature, the form should be sent from the NHSL email account of the clinician making the request.**

**Tick all that apply or state nil – Please do not leave blank**

|  |  |  |
| --- | --- | --- |
| **Clinician Name** | **Signature** | **Date** |
|  | **Specific Interest (relates directly to the medicine in this application)** | **Non-Specific Interest (relates to the relevant company)** |
| **Personal Interest (payment/fees/resources received personally)** |  |  |
| **Non-Personal Interest (payment/ fees/resources your MCN/ department/colleagues have received)** |  |  |

**Details of interest:**

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| --- | --- | --- |
| **Supporting Pharmacist Name** | **Signature** | **Date** |
|  | **Specific Interest (relates directly to the medicine in this application)** | **Non-Specific Interest (relates to the relevant company)** |
| **Personal Interest (payment/fees/resources received personally)** |  |  |
| **Non-Personal Interest (payment /fees/resources your MCN/ department/colleagues have received)** |  |  |

**Details of interest:**

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| **Approved at ADTC** | **Date** |
| **Formulary website updated** | **Date** |