Lanarkshire Joint Formulary
Formulary Amendment Request Form

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)** 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 (S[1]): 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 (S[2]): 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

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SECTION 3-Details of Change Requested

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
☐	☐	☐

Proposed formulary category: tick appropriate box (see above for details of category)			
PREFERRED LIST (P) ☐	TOTAL LIST (T) ☐	SPECIALIST 1 (S^1) ☐	SPECIALIST 2 (S^2) ☐
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	

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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:

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:

Approved at ADTC	Date
Formulary website updated	Date