**Drug and Therapeutics Group**

**Application for Addition to the Joint Formulary**

|  |  |
| --- | --- |
| **Drug Name:** |  |

This form should be used to apply for an addition/change to the Joint Formulary. **All sections of this form must be completed in full** - it will be returned without consideration if any details are omitted. **Please fill in this form electronically**.

**Both an electronic copy and a printed and signed paper copy** must be submitted before any applications will be considered for inclusion on the next group meeting agenda.

Submissions must be made four weeks prior to the next DTG meeting to be accepted on to the agenda. All application must be submitted to the Drugs and Therapeutics Group via [mccg.dtc@nhs.net](mailto:mccg.dtc@nhs.net). Details of submission deadlines and for further information on the DTG can be provided on request.

**\*\*Each submission must also be reviewed by a senior pharmacist.\*\***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Requester information** | | | | | | | |
| **Name** | |  | | | | | |
| **Email** | |  | | | | **Tel. Number** |  |
| **Signature** | | *[required on paper copy]* | | | | | |
| **Directorate/ Department** | |  | | | | | |
| **Area(s) of use**  (Please X the relevant box) | | Primary Care  Secondary Care  Other Specialist team | | | | | |
| **Is the requested drug for this indication included in national guidance?** | | | | | Yes  No | | |
| **State which guidance and attach copies to application** | | | | |  | | |
| **Is the requested drug for this indication included in (Either CCG/MFT) local guideline?** | | | | | Yes  No | | |
| **State which local guideline and attach copies to application** | | | | |  | | |
| **Senior/Lead Pharmacist information** | | | | | | | |
| **Pharmacist Name** | |  | | **Position** | |  | |
| **Pharmacist Email** | |  | | | | **Ext. Number** |  |
| **Pharmacist Signature** | | *[required on paper copy]* | | | | | |
| **Declaration of Conflict of Interest** | | | | | | | |
| *Please declare any conflict of interest -* | | | | | | | |
| **Application type (Please X the relevant box)** | | | | | | | |
| **New medicine item**  **Amendment of an existing Formulary item** | | | | | | | |
| **Medicine details** | | | | | | | |
| **Generic name** |  | | | | | | |
| **Brand name** |  | | | | | | |
| **Formulation/strength** |  | | | | | | |
| **Licensed Indication (s) (detailed in the product summary of characteristics (SPC))** |  | | | | | | |
| **Indication(s) for proposed use:** |  | | | | | | |
| **Licensed Dosing regimen** (from SPC) |  | | | | | | |
| **Treatment type**  (Please x the relevant box) | | | Long term use  Short term use | | | | |
| **The use of this product is** (Please x the relevant box) | | | Licensed  Unlicensed  Off label | | | | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Clinical information** | | | | | | | | | | |
| **Is this drug** | Established treatment | | | New drug | | | Investigational drug | | | |
| **Does the drug** | | Cure | | Prolong life | | | Relieve symptoms | | | |
| **What percentage of patients would you expect to be cured by this treatment?** | | | | | | | | % | | |
| **What 5 year mortality do patients treated with this drug have?**  (Please X the relevant box) | | | Normal  <35%  35-75%  >75% | | | | | | | |
| **List the existing formulary drugs (and non-pharmacological therapies) for treating the requested indications (include prices)** | | | | |  | | | | | |
| **Place in therapy**  (Please X the relevant box) | | | 1st Line  2nd Line  3rd Line | | | | | |
| Replace Current drug | | | **(please specify)** | | | | |
| **For restricted use in specific patient groups?**  (Please X the relevant box) | | | Yes  No | | | | | |
| **If yes, provide details** | | |  | | | | | | | |
| **In efficacy is this drug?**  (Please X the relevant box) | | | Unique, can’t be compared to existing therapy  Better than existing therapy  Same as existing therapy  Worse than existing therapy | | | | | | |
| **Define the treatment objective or therapeutic endpoint** | | |  | | | | | | | |
| **List the pivotal studies that demonstrate the safety and efficacy of this drug. Attach references with the application.** | | |  | | | | | | | |
| **Please list the key advantage(s) of the drug over existing drugs, or non-pharmacological therapies? (e.g. in terms of safety, tolerability, efficacy, price or patient factors like ease of use).**  **Must cite evidence.** | | |  | | | | | | | |
| **What is the dosage scheduling you intent to use? *Include duration where applicable*** | | |  | | | | | | | |
| **What are the side effects of this drug? Include incidence and severity** | | |  | | | | | | | |
| **Patient Benefits** | | | | | | | | | | |
| **Please Summaries the key benefits to the patient.**  This may include non-clinical benefits i.e. reduced hospital/clinic visits, reduced pill burden etc. | | |  | | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Where will the drug be prescribed?**  (Please X all relevant boxes) | | | Primary Care  Secondary Care | | |
| **If the drug is/will be prescribed in primary care, what is the current/anticipated Formulary status?** | | | Medway and Swale Joint Formulary  <http://www.medwayswaleformulary.co.uk/> | | |
| |  |  | | --- | --- | | Red – Specialist prescribing Only |  | | Amber – Specialist Initiation Only |  | | Green – First Line |  | | Black – Can be prescribed |  | | | |
| **Is the drug PBR excluded?**  (Please X the relevant box) | | Yes | | No | |
| **How is the drug funded?**  (Please X the relevant box) | | Trust CCG NHSE | | | |
| **How much does the drug cost per month/per treatment course?** | Hospital cost (£):  Primary care cost (£): | | | | |
| **Please specify the source from which these values have been calculated (i.e. BNF price, contract price)** |  | | | | |
| **Comparing like with like, does the drug?**  (Please X the relevant box)  Cost more than existing treatment  Cost the same as existing treatment  Cost less than existing treatment  No comparable treatment | | | | | |
| **Anticipated No. of patients to be treated per year** | | | | |  |
| **Cost per patient per course** | | | | |  |
| **Total cost per year** | | | | |  |

|  |
| --- |
| **References:** |
| Please insert references below |

|  |  |
| --- | --- |
| **Traffic Light Status Information** | |
| Status | Description |
|  | Medicines suitable for routine use and can be prescribed within secondary care within their licensed indication in accordance with the BNF or other recognised national formulary. Primary care prescribers take full responsibility for prescribing |
|  | Medicines that should be initiated by a specialist and can be continued in primary care only under a shared care agreement and once the patient has been stabilised. Prior agreement must be obtained by the specialist from the primary care provider before prescribing responsibility is transferred. The shared care protocol must have been agreed by the relevant secondary care trust Drugs and Therapeutics Committee(s)(DTC) and approved by Medway and Swale CCGs. |
|  | Medicines which should be prescribed by specialists only |
| **Black** | Can be prescribed |
| Do Not Prescribe List | Drugs that have been reviewed and not recommended for prescribing. These drugs are not considered a cost effective use of scarce NHS resources. There may be individual patient specific or clinical reasons why a drug deemed low priority may be suitable for a particular patient. This is for the GP to consider, weighing up the reasons against his/her allocated CCG budget. Where the decision is made to prescribe a low priority drug, detailed documentation must be included within the patients' notes for audit purposes. |

**Please note** that all applications made to DTG will follow one of the pathways set out below.

Application originating from the Trust

Application originating from the CCG