

# Application for a Medicine to be Added to the Northern Lincolnshire Formulary



Northern Lincolnshire  
Area Prescribing Committee

This form is to be used for applications for new medicinal products, new formulations and extensions to previously agreed uses for medicinal and other relevant, pharmaceutical products to be prescribed by NHS services. Applications must include evidence-based information outlining the efficacy, therapeutic advantage, safety, financial impact of the new product and the cost relative to the products already used. Supporting documents should be from randomised controlled studies, NICE and from professional, peer reviewed journals. Requests must be made by an appropriate clinician or other senior professional, for example a pharmaceutical advisor, dentist or optician.

- Please complete all sections. Incomplete forms will not be processed.
- The form should be submitted electronically via email to the APC Professional Secretary. The relevant details are clearly outlined on the APC website.
- The application should be supported by the relevant clinical speciality groups and/or individuals as outlined in Section 2. All relevant groups and individuals from the organisation submitting this Formulary Request must have commented on the request and dated the form before the APC will consider the application.
- An application for a drug that has been rejected within the last twelve months will normally be refused unless supported by new evidence or new licenced indications.
- The manufacturer (pharmaceutical company) may provide information supporting the application, but the application must originate from an appropriate professional.
- Where possible, electronic versions of any references and other supporting documents should be submitted electronically along with this Formulary Request.
- Hospital consultants are required to discuss their request and obtain support from their business/finance lead and other specialists within their department.
- Do not submit patient identifiable details with this Formulary Request.

APC Meetings are held on a monthly basis. Decisions regarding the addition of a new product to the Formulary will take place when feedback from the organisations involved (North Lincolnshire CCG, North East Lincolnshire CCG and Northern Lincolnshire and Goole Foundation Trust) has been received. If the feedback is not received at least two weeks prior to the next APC meeting, the decision will be made at the subsequent meeting. Feedback from your application will be given within 14 weeks of receipt of a fully completed Formulary Request.

**Please submit via the APC website. For full instructions, click 'Submit Formulary Request' in the menu of the website. Alternatively email this form to APC Professional Secretary Michelle Marshall [michelle.marshall3@nhs.net](mailto:michelle.marshall3@nhs.net)**

**\*\*\* To select a check box, double click on the square and select the 'checked' option \*\*\***

**Please complete this form clearly and accurately. Avoid pasting lengthy documents into this form. Please attach relevant documentation together with this form or provide links to web references in Section 9.**

# Application for a Medicine to be Added to the Northern Lincolnshire Formulary



Northern Lincolnshire  
Area Prescribing Committee

## Request Summary

1. APPLICANT DETAILS		
Name	Position	NHS Organisation
Department (If Hospital) / Practice (If CCG)	Email Address	Telephone

2. Compulsory Support from Department or Practice, Specialty Lead, Prescribing Lead, Organisation Group (e.g. M&T) and Business / Finance Officer			
This section must be completed fully before the APC will consider the Formulary Request.			
Name of supporting individual or group	Organisation	Comment	Date of Review
Department or Practice e.g. Dermatology or Medical Practice Name			
Clinical Specialist e.g. Consultant or GPSI (if applicable)			
Group or Prescribing Lead e.g. M&T or Named CCG Prescribing Lead			
Business / Finance Official e.g. Business Manager or Contracting Lead			
Area Prescribing Committee Final Outcome	Northern Lincolnshire APC		

3. DETAILS OF DRUG			
Non-proprietary name:		Brand name:	
Dosage form and strength:			Tick if applies Unlicensed Drug <input type="checkbox"/> Unlicensed Indication <input type="checkbox"/>

4. INDICATIONS	
Licensed indication for this medicine (see SPC):	

# Application for a Medicine to be Added to the Northern Lincolnshire Formulary



Northern Lincolnshire  
Area Prescribing Committee

Indication for which the medicine is requested	
--	--

## Additional Information

<b>5. REASON FOR REQUEST</b>		
Tick one or more boxes	Therapeutic advantage over existing treatment <input type="checkbox"/> Cheaper than alternative treatment <input type="checkbox"/> Improved compliance <input type="checkbox"/>	No alternative <input type="checkbox"/> New formulation <input type="checkbox"/> Other (please specify) <input type="checkbox"/>
If there are advantages over existing medicines for the same indication(s), please state here.		

<b>6. ANTICIPATED PLACE IN THERAPY</b>
Please give a clear guideline including algorithms or flowcharts, indicating which group(s) of patients should and should not be eligible to receive this medicine, including details of whether the drug is 1 <sup>st</sup> line or not and the suggested criteria for selecting or not selecting the drug. Either explain below or attach a pathway.

<b>7. PRESCRIBING AND MONITORING</b>		
Dosage regimen proposed for this application:	Dose and Frequency	Likely duration of treatment
Monitoring requirements (including criteria for stopping treatment) & implications for continued care:		

# Application for a Medicine to be Added to the Northern Lincolnshire Formulary



Northern Lincolnshire  
Area Prescribing Committee

Prescriber restrictions: (e.g. Consultant only).	
---	--

## 8. FINANCIAL ASPECTS

Please complete the following to allow likely usage and costs to be calculated.

No of patients likely to be treated <b>per year</b> region wide	Average daily dose	Likely duration of treatment	Proportion of treatment likely to be supplied by the Hospital Trust

If you already have an estimate of the likely cost (to your directorate or CCG) of using this product, please give details below:

<b>Estimated cost:</b> If a business case has been prepared involving the use of this product please enclose details with this form	In next 12 months £  Subsequent Years £
Details of how estimated costs have been calculated	
Details of compensatory saving resulting from use of new product (please include details of possible savings in areas other than drugs expenditure)	
What is the likely impact of this product on primary care prescribing?	

## 9. SUPPLEMENTARY DETAILS

Please give a concise outline of any additional information you would like to be considered along with this Formulary Request. This can include links to trial data, SIGN documents, NICE Guidance, SMC Guidance, Trial Data or any other relevant information.

--

## 10. DECLARATION OF INTEREST

Members of the Area Prescribing Committee declare interests prior to discussing items relating to individual products. It is requested that applicants do the same.

Details of any support or sponsorship (for staff, clinical trials, other research etc.) received or likely to be received from the manufacturer of this product within the last/next 12 months. If none, state 'NONE'

# Application for a Medicine to be Added to the Northern Lincolnshire Formulary



Northern Lincolnshire  
Area Prescribing Committee

Personal:		Departmental:	
Applicant's name:*		Date:	
* By electronically submitting this form, you are confirming that you are the individual named above and that you have authority to use this system as set out in the terms and conditions. All applications will be scrutinised.			