|  |  |
| --- | --- |
| **MENTAL HEALTH SERVICES**  **Non- Formulary Request Form and Decision Record** | NHSGGC - logo - colour |

**Notes for electronic completion:**

This document can be completed by adding text to the grey text fields and by checking the tick boxes or selecting from drop-down boxes where applicable. It should be completed, saved and submitted electronically.

**How to submit the request:**

1. Send the completed form to the Mental Health Prescribing Management Group (PMG-MH)

[PrescribingManagementGroup.MentalHealth@ggc.scot.nhs.uk](mailto:PrescribingManagementGroup.MentalHealth@ggc.scot.nhs.uk)

1. Following a decision, you will be advised of the outcome via email, attaching a copy of the completed paperwork, a copy of which should be filed in the patient’s medical notes
2. For any queries relating to the process, contact the Mental Health Pharmacy Team on 0141 211 6525/ 6526 or via the email address above.

**Parts A&B - to be completed by the requesting clinician**

**PART A: NON-FORMULARY REQUEST DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient’s CHI Number:** |  | **Patient Postcode:** |  |

|  |  |
| --- | --- |
| **Patient’s NHS board:**  *(Please select from the drop-down list)* |  |
|  |  |
| **Hospital:**  *(Please select from the drop-down list)* |  |

|  |  |
| --- | --- |
| **Requesting Clinician:** |  |
|  |  |
| **Email address:** |  |

|  |  |
| --- | --- |
| **Medicine and formulation:** |  |
|  |  |
| **Intended indication:** |  |

|  |  |
| --- | --- |
| **Status of this medicine:**  *(Please select from the drop-down list)* |  |

|  |  |
| --- | --- |
| **The patient understands the process:**  *(The clinician should explain the process to the patient)* | Tick here to confirm |

|  |  |
| --- | --- |
| **Multidisciplinary team support:**  *(the clinician has discussed the request with the MDT and gained their agreement and support)* | Tick here to confirm |
| **and/or Peer approval:**  *( if deemed appropriate)* | Tick here to confirm |

|  |  |
| --- | --- |
| **Name and position of peer :** |  |

In accordance with the Code of Conduct of NHS Greater Glasgow and Clydeyou are required to declare all interests you have in the pharmaceutical company which markets the medicine you are requesting on this form. It is possible that these may be checked against the national ABPI Interests database. Declared Interests do not directly impact on the process or decision, but are required to be noted to ensure transparency of process.

|  |  |
| --- | --- |
| **Declaration of interests:**  *(Please select from the drop-down list)* |  |
| * Personal interests may be payments/fees/resources etc that you have received personally from the company * Non-personal interests may include payments/fees/resources etc. that your department has received from the company * Specific interests are those that relate directly to the medicine you are requesting * Non-specific interests are those that relate to the company, but not directly to the medicine you are requesting | |
| **Details of any declared interests:**  *(Where applicable)* |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **By ticking this box I confirm that I am the clinician named above in charge of the patient’s care:** |  | **Date:** |  |

**PART B: NON-FORMULARY CASE FOR PRESCRIBING**

The clinician who wishes to prescribe the requested medicine is expected to demonstrate the clinical case.

**Information directly relating to Decision Making Criteria:**

|  |  |
| --- | --- |
| **Please provide background clinical information to demonstrate the rationale for the treatment choice and why other medicines are deemed unsuitable.** |  |
|  |  |
| **Previous treatment received by patient for this indication.**  *(including dose, duration and response)* |  |

|  |  |
| --- | --- |
| **What outcome measure(s) will be used to ascertain a response to requested treatment?** |  |

|  |  |
| --- | --- |
| **Under what circumstances would the requested treatment be reviewed or discontinued?** |  |

|  |  |
| --- | --- |
| **Information directly relating to the medicine:** | |
| **Evidence- base/ Information to support request:**  *(Please provide full citations for any clinical papers referred to)* |  |

**PART C: NON-FORMULARY DECISION RECORD**

**To be completed by MH-Prescribing Management Group Representative**

|  |  |
| --- | --- |
| **NON-FORMULARY DECISION:**  *(Select from the drop-down list)* |  |

|  |  |
| --- | --- |
| **Rationale for submission not supported:**  *Where a request has been rejected, the reasoning must be clearly stipulated to allow the patient & clinician to be able to understand the rationale for the decision made.* |  |

**Authorisation by MH-Prescribing Management Group**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name and position:** |  | | |
|  |  | | |
| **Declaration of interests:** |  | | |
|  |  | | |
| **By ticking this box I confirm that I am the Clinical Director (or nominated deputy) named above:** | | **Date:** |  |

**PMG-MH will retain a copy of this form for audit purposes.**

**The completed request and decision should be filed within the patient’s medical notes/ uploaded on to EMIS**.