­­**Bedfordshire, Luton and Milton Keynes Area Prescribing Committee (BLMK APC) – Formulary Subgroup**

*Please see Appendix 1 for general guidance on how to complete and submit for discussion and approval.*

*Please note this form can only be used for medicines or devices that exist on either the Bedford/Luton or the Milton Keynes Formularies for licensed uses. For new additions please use the full application form.*

**Request for Amendment to the Formularies**

**[Enter date]**

**Agenda item X.X**

**Title**

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| --- |
| **What is the item?** |
| **What is the APC being asked to discuss?** |
| **Who is bringing this to the APC?** |
| **What are the options available?** |
| **Option 1:** |
| **Option 2:** |
| **Option 3:** |

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| **Reason for application:**  *Guidance notes: What changes need to be made and which Formulary is affected? What is the driver for this request? E.g. Is this in response to new guidance? What is in place at the moment that needs to change and why?* |
|  |
| **Service user impact:**  *Guidance notes: How will this change benefit service users? Are there any risks associated with the change? Might the change restrict or remove access to a treatment? What other options remain in place?* |
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| **About the medicine(s)/device(s):**  *Guidance notes: Please provide detail on the affected medication and indication* |
| **Name**: |
| **Strength/formulation/route**: |
| **Dosage and duration of therapy**: |
| **Indication:** |
| **Change(s) required:** |
| **Proposed traffic light designation:** |
| **Cost Impact & patient numbers:**  *Guidance notes: Will the change represent a cost-saving or a cost-pressure? Will costs be shifted from secondary to primary care as a result of the change? Please give details of expected costs and expected patient numbers here.*  *Include source of cost information and whether VAT is included. Please also consider non-drug costs e.g. appointments, blood tests and consumables* |
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| **Stakeholder comments (if applicable)**  *Guidance notes: Include here any support/comments from stakeholders. Please attempt to obtain comment from those that will initiate, monitor and continue the therapy across the relevant settings e.g. secondary care / primary care / clinics* |
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**Bedfordshire, Luton and Milton Keynes (BLMK) Area Prescribing Committee (APC)**

**Assessment against Ethical and Commissioning Principles**

|  |  |
| --- | --- |
| **Treatment assessed (Month and Year):** | |
| **APC Recommendation**  TBC post meeting | |
| 1. **Clinical Effectiveness**   *e.g. according to national guidelines…* | |
| 1. **Cost Effectiveness**   *e.g. most appropriate and cost- effective products have been recommended* | |
| 1. **Needs of the community**   *e.g. prevalence and incidence of disease being treated?* | |
| 1. **Equity & Equality Impact Assessment** (see also embedded additional information including factsheet below to aid completion of this section)   Consider whether this decision of the APC will have an impact for patients or staff in regard to Equality, Inclusion and Human Rights legislation.  Such impacts (negative) could include:   * Restriction of a drug which could benefit those with certain conditions1,2   Where the implementation of the decision of the BLMK APC may impact on one or more equality group differently to others, a full equality impact assessment may need to be completed as advised by the BLMK Equality and Diversity Lead.  **Protected Characteristics (under the Equality Act 2010):**  Age; Disability; Gender reassignment; Marriage & Civil Partnership (in employment only); Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual orientation; carers; other identified groups.    1 NB Equality and Diversity is only one part of an assessment of the new drug/indication.  2 It should be noted that where the BLMK APC is following national guidance, these have been developed with consultation and are required to have been subject to Equality Analysis and Due Regard. | |
| Please state whether the decision will have an impact: | |
| Yes  No | *If* ***YES,*** *the proposal is likely to impact patients or staff. Please set out those impacts and any mitigations that have been identified in the section below. Examples include a process where the needs of exceptional cases can be met.*  ***NO****, please state that the decision has been reviewed with regard to Equality, Inclusion and Human Rights and no issues have been identified in the section below.* |
| Provide rationale for impact assessment:  *Should a significant impact be identified a full EQIA should be completed* | |
| 1. **Need for healthcare (incorporates patient choice and exceptional need**)   *e.g. are there alternative therapies available or is this a completely new treatment option?* | |
| 1. **Policy drivers:**   *e.g. relevant local or national guidance* | |
| 1. **Disinvestment:**  * *How will this medicine help to address local health priorities?* * *By using this medicine, what disinvestment in other medicines, interventions and services may be possible?* * *How much would this save?* * *Affordability considerations?* * *Will this medicine help to address local health priorities?* | |
| 1. **Environmental impact of decision (if applicable)** | |

**Declaration of Interest:**

I confirm that I have no conflicts of interest in relation to this application

I have a conflict of interest to declare and enclose further information

**See link to** [**DOI form and information**](https://medicines.blmkccg.nhs.uk/guideline/declaration-of-interests-form-template/)

|  |  |
| --- | --- |
| Name: |  |
| Job title: |  |
| Signature: |  |

**Applicant Information:**

|  |  |
| --- | --- |
| Name: |  |
| Job title: |  |
| Signature: |  |
| Date: |  |
| Contact information: |  |

**Appendix 1: General guidance for completing the form:**

* Please complete the form in full. Any blank sections will be sent back for completion by the applicant.
* It is expected that applications will have considered patients across the entire ICB to ensure equity of access for all of the patients within our all of our areas and a harmonised approach within the system. Where an application covers only a selection of patients please state the reason for this.
* Primary and Secondary Care will inform each other immediately, via Chief Pharmacists / Formulary Pharmacists, where drug use or the effect on patient pathways if an application is relevant to their organisation.
* The application must reflect consensus from your directorate / CSU / specialty / area.
* Submit completed forms to the place-based lead pharmacist.

Contact details:

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| --- | --- |
| BLMK Integrated Care Board | [blmkicb.medsopt@nhs.net](mailto:blmkicb.medsopt@nhs.net) |
| Bedfordshire Hospitals NHS Foundation Trust | [bhn-tr.medicinesinformation.formulary@nhs.net](mailto:bhn-tr.medicinesinformation.formulary@nhs.net) |
| Cambridgeshire Community Service NHS Trust | [ccs.pharmacyteam@nhs.net](mailto:ccs.pharmacyteam@nhs.net) |
| Central and North West London NHS Foundation Trust | [cnwlmiltonkeynespharmacy@nhs.net](mailto:cnwlmiltonkeynespharmacy@nhs.net) |
| East London NHS Foundation Trust | [elft.pharmacybchs@nhs.net](mailto:elft.pharmacybchs@nhs.net) |
| Milton Keynes University Hospital NHS Foundation Trust | [Prescribing.Formulary@mkuh.nhs.uk](mailto:Prescribing.Formulary@mkuh.nhs.uk) |

**Submission to the BLMK Formulary Subgroup**

* The BLMK Formulary Group meetings are scheduled for five dates over the year. Please see the [BLMK Website](https://medicines.bedfordshirelutonandmiltonkeynes.icb.nhs.uk/categories/formulary/) for dates.
* Applications should normally be submitted 6 to 8 weeks before the meeting, whenever possible.
* The place-based Formulary Pharmacist / APC professional secretary will notify you of the date of the meeting when the application will be considered, subject to the receipt of all necessary information including that relating to sources of funding.
* You will be invited to attend to put forward the case for inclusion and answer any questions the group may have. If you are unable to attend, you may send a representative on your behalf or request to defer to a later meeting date.
* Submissions will be considered, at the discretion of the Chair of the BLMK Formulary Group, in the absence of the applicant if appropriate information is available at the time when the agenda and papers are prepared.
* Applicants will not be present when the BLMK Formulary Group/APC discusses its recommendation or decision.
* We suggest that you contact your organisation’s pharmacy/medicines management service before you complete this form, so that they may provide you with support and advice on the process.

**Please email** [blmkicb.medsopt@nhs.net](mailto:blmkicb.medsopt@nhs.net) **for further information regarding any of the above.**