**REQUEST FORM FOR ADDITIONAL 12 WEEKS SUPPLY OF DAKLINZA® BEYOND THE INITIAL 12 WEEKS**

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| **Product Name : Daklinza® (Daclatasvir)** | **Date emailed to BMS (dd/mm/yyyy):**  |

 **PHYSICIAN INFORMATION**

Principal Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy contact information**

Institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy contact email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: (office) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mobile) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Site’s unique patient identifier (should not be the NHS number) ...........................**

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| SUPPORTING INFORMATION :  |
| **MDT Review Date  (dd/mm/yyyy):** |
| **Daklinza® (Daclatasvir) Daily Dose :** [ ]  30mg [ ]  60mg [ ]  90mg |
| **Genotype :** [ ]  GT1 [ ]  GT2 [ ]  GT3 [ ]  GT4 |
| **Treatment duration received so far** [ ]  4 weeks [ ]  8 weeks [ ]  10 weeks [ ]  other : please state ………………  |
| **Dispensed in :** [ ]  Hospital [ ]  Homecare**For hospital dispensing, complete the following:*** **Dispensing Pharmacy information : If different from Pharmacy contact information above**
	+ **BMS Account Number**
	+ **Pharmacy Name :**
	+ **Address :**
	+ **Telephone Number :**
* **Number of Packs Required (please state units):** [ ]  30mg [ ]  60mg [ ]  90mg
* **Shipment must reach destination by (dd/mm/yyyy):**

**For dispensing through Homecare:*** **Name and postcode of Homecare company used, if applicable**
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**I confirm that the information in this form is correct and that the patient is being treated under the NHS in Scotland and is not a private patient.**

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| --- | --- |
| **Print Pharmacist Name** |  |
| **Signature & Date***(Electronic or wet signature)*  |  |

**Completed form and/or any questions regarding the form to be emailed to swati.mehta@bms.com**