**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** |

**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**