**Community Pharmacy**

**Enzalutamide Medication Provision**

**Claim Form**

## Pharmacy

## Name & Address

|  |  |
| --- | --- |
| **Date treatment commenced** |  |
| **Name of Pharmacist making claim** |  |
| **Signature or GPhC Number of Pharmacist** |  |
| **Contractor Code** |  |
| **Date** |  |
| **Amount Claimed** | **£120.00** |

Please return the completed claim form to:

**Send completed form by email to** [**fife.fifepharmacycommpharm@nhs.scot**](mailto:fife.fifepharmacycommpharm@nhs.scot)