* **Please complete Section A and B of this form (incomplete forms will be returned)**
* The form must be typed electronically and submitted as a Microsoft **Word Document** (handwritten forms and photos of forms are not accepted)
* Completed forms must be emailed from a **secure mailbox**, i.e. @nhs.scot or @lanarkshire.scot.nhs.uk (business emails are not accepted)
* **Email completed forms to:** [**ulmrequest@lanarkshire.scot.nhs.uk**](mailto:ulmrequest@lanarkshire.scot.nhs.uk)
* NHS Lanarkshire will endeavour to respond within 24 hours of receipt of request (weekdays)
* **Replies will be emailed to the community pharmacy secure shared mailbox**

(if you need access to the mailbox please contact: [nhslanarkshire.pharmacyfacilitation@lanarkshire.scot.nhs.uk](mailto:nhslanarkshire.pharmacyfacilitation@lanarkshire.scot.nhs.uk))

* **The outcome will be specified at the end of this form – see SECTION D: OUTCOME**

|  |  |  |
| --- | --- | --- |
| **SECTION A: COMMUNITY PHARMACY TO COMPLETE**  *DELETE YES/NO AS APPROPRIATE* | | |
| 1. Is the product? | Licensed (e.g. check BNF) | **YES/NO** |
| Listed in Scottish Drug Tariff Part 7S or 7U | **YES/NO** |
| Available from UK NHS Manufacturing Site | **YES/NO** |
| ***If YES to any of the above – authorisation not required*** | |
| 2. Have you previously had authorisation for this product for this patient? | **YES/NO**  *If NO – skip Q3&4 then complete Section B of this form* | |
| 3. Has the previous authorisation expired? | **YES/NO**  *If YES – skip Q4 then complete Section B of this form* | |
| 4. Does the product price now vary by >20% from original price authorised? | **YES/NO**  *If YES – complete Section B of this form*  *If NO – authorisation not required* | |

|  |  |
| --- | --- |
| **SECTION B: COMMUNITY PHARMACY TO COMPLETE** | |
| Community pharmacy name & address |  |
| Community pharmacy telephone number |  |
| Community pharmacy contractor code |  |
| Community pharmacist contact name |  |
| Community pharmacy secure shared mailbox address |  |
| Prescriber name |  |
| Medical practice name & address |  |
| Date of prescription |  |
| Patient CHI number |  |
| Name of product prescribed |  |
| Strength |  |
| Formulation |  |
| Dose |  |
| Quantity to supply |  |
| Name of company that can supply product |  |
| Pack size |  |
| Cost per pack *(provide most cost-effective quote – you may need to contact >1 supplier)* |  |
| Any comments |  |
| Date form completed and emailed |  |

|  |  |
| --- | --- |
| **SECTION C: ADMIN OFFICE TO COMPLETE** | |
| **Best cost available** | As stated by community pharmacy  As follows;   |  |  | | --- | --- | | Strength |  | | Formulation |  | | Pack size |  | | Cost per pack |  | | Supplier |  | |
| **Initials** |  |
| **Date** |  |

|  |  |
| --- | --- |
| **SECTION D: OUTCOME** | |
| **LOCALITY PRESCRIBING SUPPORT TEAM TO COMPLETE**  *Delete as appropriate* | |
| **Authorisation declined** | Product licensed  Switched to alternative licensed product  Switched to alternative off-label product  Listed in Scottish Drug Tariff Part 7S or 7U  Available from NHS Manufacturing Site  Other: |
| **Cost authorised** | As stated by community pharmacy  As follows;   |  |  | | --- | --- | | Strength |  | | Formulation |  | | Pack size |  | | Cost per pack |  | | Supplier |  | | *Note: The Board will authorise the product at this cost as it has evidence that it is available from a supplier at this cost (the pharmacy may however choose which supplier to source the product from)* | | |
| **Duration authorised** | This prescription only  Other:  12 months (max.) |
| **Initials** |  |
| **Date** |  |