* **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**
* 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)

* **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** |  |