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| **Formulary Amendment Form** |

*Please read the supporting guidance that is available on the* [*formulary website*](https://formulary.nhs.scot/east/help-and-support/formulary-governance/formulary-application-process/) *before completing.*

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| **Medicine Information** *(medicine details can be checked on the* [*dm+d browser*](https://dmd-browser.nhsbsa.nhs.uk/)*)* |

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| Amendment type | Choose an item. |
|  |  |
| Name of medicine | Name of medicine? (for replacements please detail the new medicine) |
|  |  |
| Formulation | Please detail the formulation(s) of the medicine? |
|  |  |
| Route of administration | What is the route of administration? |
|  |  |
| Indication | What is the indication? |

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| **Place on Formulary** |

|  |  |
| --- | --- |
| Therapeutic area | Choose an area of the formulary. If not listed please type here. |
|  |  |
| Will this medicine replace another formulary medicine? | Choose an item. |
|  |  |
| Which medicine? | If yes, which medicine will it replace? |
|  |  |
| Rationale for change | What is the rationale for this change? |
|  |  |
| Cost implications | What are the cost implications of this change? |
|  |  |
| Proposed position | Choose the position this medicine should be on the formulary.*(**Contact us* *for support on amending or creating pathways)* |
|  |  |
| Rationale for position | What is the rationale for choosing this position? |
|  |  |
| Formulary flags | [ ]  | - | None |
|  | [ ]  |  | Specialist Initiation |
|  | [ ]  |  | Specialist Use Only |
|  | [ ]  |  | Unlicensed Medicine |
|  | [ ]  |  | Unlicensed Indication |
|  |  |
| Rationale for flags | What is the rationale for this choice of flag(s)? |
|  |  |
| Has a local clinical management guideline been developed/updated? | Choose an item.(If yes, please attach a copy of the guideline with this application) |
|  |  |
| Has an implementation plan been produced? | Choose an item.*(If yes, please attach a copy of the plan with this application)* |

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| **Additional Information** |

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| Support for this formulary amendment from NHS Borders, NHS Fife and NHS Lothian | Please provide details of the support you have received from each of the three boards for making this amendment to the formulary. |
| Additional information | Please add any additional information you wish to be considered as part of this application. |

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| **Applicant Details & Declaration of Interests (last 3 years)** |

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| --- | --- |
| First name | Click or tap here to enter text. |
|  |  |
| Surname | Click or tap here to enter text. |
|  |  |
| Health Board | Choose an item. If not listed please type here. |
|  |  |
| Position held | Click or tap here to enter text. |
|  |  |
| Email address | Click or tap here to enter text. |

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| Do you have a **personal specific** interest to declare? Select.If yes, enter the nature of the interest being declared here. |
| Do you have a **personal non-specific** interest to declare? Select.If yes, enter the nature of the interest being declared here. |
| Do you have a **non-personal specific** interest to declare? Select.If yes, enter the nature of the interest being declared here. |
| Do you have a **non-personal non-specific** interest to declare? Select.If yes, enter the nature of the interest being declared here. |

* **I declare** that the information I have given is correct and complete.
* **I understand** that if I knowingly provide false information this may result in disciplinary action and I may be liable for prosecution and civil recovery proceedings.
* **I understand** this form is a public record, and it will be made available for audit or other inspection, or disclosure under the Freedom of Information Act.

|  |  |
| --- | --- |
| Name: Enter full name. | Date: Select a date. |

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| **Supporting Pharmacist Details & Declaration of Interests (last 3 years)** |

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| First name | Click or tap here to enter text. |
|  |  |
| Surname | Click or tap here to enter text. |
|  |  |
| Health Board | Choose an item. If not listed please type here. |
|  |  |
| Position held | Click or tap here to enter text. |
|  |  |
| Email address | Click or tap here to enter text. |

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| Do you have a **personal specific** interest to declare? Select.If yes, enter the nature of the interest being declared here. |
| Do you have a **personal non-specific** interest to declare? Select.If yes, enter the nature of the interest being declared here. |
| Do you have a **non-personal specific** interest to declare? Select.If yes, enter the nature of the interest being declared here. |
| Do you have a **non-personal non-specific** interest to declare? Select.If yes, enter the nature of the interest being declared here. |

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* **I understand** this form is a public record, and it will be made available for audit or other inspection, or disclosure under the Freedom of Information Act.

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| Name: Enter full name. | Date: Select a date. |

**The applicant should return the form by email to** **eos.prescribing@nhs.scot** **copying in the supporting Pharmacist.**

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| **For internal use only** |

**Additional Information**

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| Additional information for Formulary Committee reviewer: | Additional information for formulary committee reviewer. |

**Formulary Committee Decision**

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| Formulary status: | What is the status of this application? |
|  |  |
| Rationale: | What is the rationale for this status? |
|  |  |
| Other comments/actions: | Capture any comments or actions required here. |
|  |  |
| Date: | Select a date. |
|  |  |
| Additional information: | Capture any additional information here (e.g. details provided by clinical team.) |