



**USE OF MEDICINES COMMITTEE**

c/o Pharmacy Department

University College Hospital

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London, NW1 2BU

**Email:** [**uclh.umc@nhs.net**](mailto:uclh.umc@nhs.net)

**North Central London**

**Joint Formulary Committee**

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| **Application form for the use of a new medicine (or indication) in**  **UCLH or North Central London** |

The North Central London (NCL) Joint Formulary Committee’s (JFC) role is to advise Commissioners and Provider Trusts on appropriate, equitable, evidence-based and cost-effective use of medicines. The collaboration between JFC and Use of Medicines Committee (UMC) at UCLH is outlined in the flow chart.

Attached is an application form for a new medicine [or indication] to be reviewed by the NCL JFC or the UMC. Both these Committees are driven by an evidence-based approach and this form is designed to help you highlight the benefits of your chosen medicine. New medicines will be recommended if they offer a significant advantage over existing formulary products. An advantage may be conferred by improved:

* Efficacy
* Safety
* Convenience
* Cost

It is essential that all relevant sections are filled in legibly and comprehensively to avoid delaying your application. If the form is not fully complete then your application cannot be processed. Please note that budgetary approval will also be required prior to submission of the application.

You will receive email confirmation from the UMC or JFC secretariat of its acceptance, advised which Committee will review the application and the date on which it can be heard. Other stakeholders within NCL will also be invited to make comment. You will be invited to attend the meeting, but attendance is not mandatory (although preferred). On the day of the meeting, a Committee nominee will present a summary of your application and you will be given the opportunity to voice any errors, misinterpretations or omissions. The Committee members may also take this opportunity to ask you any questions regarding the application. You will then be asked to leave and the outcome decision will be communicated to you [and other stakeholders] via email one to two weeks after the meeting.

Please return the completed form electronically to uclh.umc@nhs.net along with accompanying treatment guidelines and electronic copies of the supporting references.

Yours sincerely,

Andrew Barron

Lead Pharmacist - Formulary, Medicines Management & Clinical Trials

On behalf of Use of Medicines Committee (UMC)

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| **Application form for the use of a new medicine (or indication) in North Central London** | | |
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| **1. APPLICANT’S DETAILS** | | |
| Applicant name: | Email address: | |
| Role: | Trust/Organisation: | |
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| **2. DECLARATIONS OF INTEREST** | | |
| Please tick any personal or non-personal interest that you may have associated with the drug or manufacturer of the medicine **within the last two years**:  **A.** ☐ **Personal Interests (any form of payment to an individual by a pharmaceutical company):** £   * **Consultancies:** any consultancy, directorship, position in or work for the pharmaceutical industry which attracts regular or occasional payments in cash or kind. * **Fee-paid work:** any work commissioned by the pharmaceutical industry for which the individual is paid in cash or kind. * **Shareholdings:** any shareholding in or other beneficial interest in the pharmaceutical industry. This does not include shareholdings through unit trusts or similar arrangements where the individual has no influence on financial management. * **Expenses/hospitality provided by a pharmaceutical company**   **B.** ☐ **Non-Personal Interests (involves payment that benefits a department for which an individual is responsible):** £   * **Fellowships:** the holding of a fellowship endowed by the pharmaceutical industry or any other relevant industry. * **Support by the pharmaceutical industry or any other relevant industry:** any payment, other support or sponsorship by the pharmaceutical or other industry that does not convey any pecuniary or material benefit to the individual personally but that benefits his/her position or department. * **Grants from a company:** for example, for the running of a unit or department for which an individual is responsible * **Grants or fellowships to sponsor a post or staff member in the unit for which the individual is responsible:** this does not include financial assistance given to individual students * **Commissioning of research or other work or advice from staff who work in a unit for which the individual is responsible**   **C. ☐ Nil declarations of interest** | | |
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| **3. MEDICINE DETAILS** | | |
| Name (generic and brand), strength & form: | | |
| Dose & frequency: | | Anticipated duration of treatment: |
| Intended indication(s) for use: | | |
| Is this product licensed for the proposed indication? Choose an item. | | |
| Starting criteria for the medicine: | | |
| Continuation criteria for the medicine (provide desired treatment outcomes, and how/when will these be assessed): | | |

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| **4. CONTEXT AND RATIONALE FOR APPLICATION** |
| What is the current treatment pathway for this condition? Include any supporting local/national/international guidance. |
| Where in the pathway does this application sit: |
| Describe the unmet need that this application addresses: |
| How would these patients be treated if the application was not approved (i.e. what is the real-world comparator for this application)? |
| Please describe below how the application addresses the unmet need.  Key efficacy benefit(s), compared to existing treatment options:    Key safety benefit(s), compare to existing treatment options:    Key patient convenience benefit(s), compared to existing treatment options: |

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| **5. EVIDENCE TO SUPPORT APPLICATION** | |
| **Reference(s)** | **Applicability to the application** |
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| Summarise any experience of using this medicine for the proposed indication (e.g. from local Trust approval for individual patients): | |

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| **6. PROVISION OF CARE** |
| Is the medicine intended for GPs to initiate?Choose an item.  Within hospitals, will prescribing be restricted to specific specialities? If yes, please describe. |
| Is the medicine intended for GPs to continue?Choose an item.  Is there a regular, ongoing need for monitoring and/or assessment of effectiveness/toxicity? If yes, please describe.    Is there a need for a shared care protocol or a GP fact sheet (ie. >2 patients per 100,000 population and regular ongoing monitoring required)?Choose an item.  After what time period would GPs be expected to take on prescribing responsibility? |
| How do potential risks of this medicine compare to current standard treatment? Consider risk of errors relating to the complexity of prescribing or administration, staff/user training requirements or patient monitoring. |
| If the medicine is for limited/restricted use, please specify how the medicine use would be controlled? |
| Compared with current standard of care, describe any impact this application will have on NHS activity. Consider activity for administration, monitoring and prescribing/dispensing.   |  |  | | --- | --- | |  | Impact on activity vs. standard-of-care (per patient) | | Outpatient appointments (e.g. monitoring): |  | | Day case appointments (e.g. administration): |  | | Inpatient bed days: |  | | Other: |  | | Primary care or community interventions: |  | |

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| **7. FINANCIAL IMPLICATIONS** | | | |
| Who is the commissioner for this service?Choose an item. | | | |
| Is the medicine classified as a high cost drug? Choose an item. | | | |
| If yes, funding from Choose an item.  If no, funding from Choose an item.  If this application is for a free of charge scheme, follow local guidance:  <https://www.ncl-mon.nhs.uk/wp-content/uploads/2020/11/JFC_Free-of-charge_Schemes.pdf> | | | |
| Specify a unit cost excluding VAT for a course (or a year) per patient:  Specify source of financial information: | | | |
| Specify the number of patients **initiated** **on treatment**:   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | Current | Year 1 | Year 2 | Year 3 | Maximum number eligible | | Trust |  |  |  |  |  | | NCL |  |  |  |  |  |   Specify the **cumulative number of patients** **on treatment**:   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | Current | Year 1 | Year 2 | Year 3 | Maximum number eligible | | Trust |  |  |  |  |  | | NCL |  |  |  |  |  | | | | |
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| **8. CONSULTATION WITH COLLEAGUES AT OTHER TRUSTS IN NORTH CENTRAL LONDON** | | | |
| Is this medication included on formulary at any other NCL Trust for the proposed indication? Choose an item.  If so, which? | | | |
| Please indicate below whether this application has been discussed with colleagues across NCL and whether they support your application:  Barnet, Enfield and Haringey Mental Health NHS Trust:Choose an item.  Camden & Islington (Mental Health) NHS Foundation Trust:Choose an item.  Great Ormond Street Hospital for Children NHS Foundation Trust:Choose an item.  Moorfields Eye Hospital NHS Foundation Trust:Choose an item.  North Middlesex University Hospital NHS Trust:Choose an item.  Royal Free London NHS Foundation Trust:Choose an item.  Royal National Orthopaedic Hospital NHS Trust:Choose an item.  University College London Hospitals NHS Foundation Trust:Choose an item.  Whittington Hospital NHS Trust:Choose an item.  Primary care:Choose an item.  Please summarise the opinions of colleagues: | | | |
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| **9. DECLARATION** | | | |
| This submission form has been completed by a clinician(s) and not by a pharmaceutical industry representative: | | | |
| Post | Name | Signature | Date |
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|  | | | |
| **10. APPLICATION SUPPORTED BY** | | | |
| Post | Name | Signature | Date |
| Divisional Director |  |  |  |
| Clinical Director |  |  |  |
| Pharmacist lead |  |  |  |

**Please email any queries, completed forms and supporting documents to** [**uclh.umc@nhs.net**](mailto:uclh.umc@nhs.net)

**INCOMPLETE FORMS WILL NOT BE ACCEPTED AND WILL BE RETURNED TO THE REQUESTING CONSULTANT**