NHS GREATER GLASGOW AND CLYDE HEALTH BOARD
REQUEST FOR CHANGES TO THE GG&C FORMULARY

INTRODUCTION

Any consultant, GP, pharmacist and qualified non-medical prescriber within NHSGG&C has the right to appeal for a medicine/ indication/ formulation to be included in or removed from the Greater Glasgow and Clyde Formulary. The following documentation should be completed in full and submitted with relevant clinical evidence.

SECTION 1: SUMMARY OF MEDICINE BEING APPEALED

APPROVED NAME:		DOSAGE FORM:	
BRAND NAME:		MANUFACTURER:	

REASON FOR APPEAL:

- Addition to GGC Formulary (complete sections 2,3, 4, 6) ☐
- Change to current formulary restrictions (complete sections 2,3, 4, 6) ☐
- Deletion from GGC Formulary (complete sections 2,3, 5, 6) ☐

SECTION 2: DETAILS OF PERSON SUBMITTING APPEAL

NAME OF PERSON COMPLETING THE APPEAL:	
DESIGNATION:	
HOSPITAL/DEPT OR PRACTICE:	

SECTION 3: DECLARATION OF INTERESTS IN THE PHARMACEUTICAL INDUSTRY

It is important that any interests are declared in any companies involved with the medicine you are appealing. Please complete this section regardless of whether you have any declared interests or not. A separate information sheet explaining about personal/non-personal and specific and non-specific interests is available to help you complete this section. If more space is needed, please provide details in section 6 of this form.

I wish to declare that I have an interest(s) in the pharmaceutical company named above:
(Please tick as appropriate) YES: ☐ NO: ☐

If you answered YES, please provide details:

CURRENT PERSONAL INTERESTS: Please provide details of interests, e.g. shares, consultancy fees etc.	
NON-PERSONAL INTERESTS: Which have arisen in the past 12 months. Please declare if these are still current.	

HAS THIS APPEAL BEEN COMPLETED IN PARTNERSHIP WITH THE PHARMACEUTICAL INDUSTRY? YES: ☐ NO: ☐

SIGNATURE: ________ DATE: ________

FORM APP1

SECTION 4: PLACE IN THERAPY (COMPLETE FOR FORMULARY ADDITIONS AND CHANGES TO RESTRICTIONS)

LICENSED INDICATION(S):	
INDICATION(S) FOR PROPOSED USE:	
PLACE IN THERAPY: e.g. First, second line agent, for use in specific patient groups etc	
CURRENT ALTERNATIVE FORMULARY CHOICES:	
WHAT ARE THE PERCEIVED ADVANTAGES OVER EXISTING THERAPY?	
ARE THERE ANY PERCEIVED DISADVANTAGES?	

HOW DO YOU ANTICIPATE THE REQUESTED PRODUCT WILL BE USED:
Tick all that apply

ADDITIONAL TREATMENT CHOICE:	
REPLACE EXISTING FORMULARY CHOICE (PROVIDE DETAILS BELOW):	
INITIATION RESTRICTED TO BY OR ON THE ADVICE OF A SPECIALIST:	
PRESCRIBING RESTRICTED TO HOSPITAL USE ONLY:	
SUITABLE FOR PRESCRIBING/ INITIATION IN PRIMARY CARE:	
USE ACCORDING TO PROTOCOL (PROVIDE DETAILS AND INCLUDE A COPY WHEN SUBMITTING THE APPEAL):	

HAS THE MEDICINE/ INDICATION/ FORMULATION EVER BEEN CONSIDERED BY THE FOLLOWING AGENCIES?
Tick all that apply and then give details of the place in therapy recommended by these agencies in the space provided on the next page

SCOTTISH MEDICINES CONSORTIUM (SMC):	
NATIONAL INSTITUTE OF HEALTH TECHNOLOGIES AND CLINICAL EFFECTIVENESS (NICE) and/ or QUALITY HEALTH IMPROVEMENT SCOTLAND (QIS): :	
SCOTTISH INTERCOLLEGIATE GUIDELINES NETWORK (SIGN):	

FORM APP1

PLEASE PROVIDE BRIEF DETAILS OF THE KEY STUDIES OR GUIDELINES SUPPORTING THE APPEAL BELOW:

Complete references or electronic links for all relevant references or information in support of the appeal have to be submitted with this form.

COST OF TREATMENT PER PATIENT:	£	**for a time period of** e.g. 1 year, 28 days treatment, full course etc
ARE THERE ANY SERVICE IMPLICATIONS ASSOCIATED WITH THE USE OF THIS MEDICINE? e.g. Diagnostic tests, monitoring, aseptic unit preparations etc		

ESTIMATED NUMBER OF PATIENTS IN NHSGG&C TO RECEIVE THIS TREATMENT OVER A 1 YEAR PERIOD

Give details of numbers and area affected (e.g. 130 new patients/year in primary care or 20 patients per year as day case etc). Consider numbers for the whole of the health board rather than your own if possible.

SECTION 5: REASONS FOR DELETION FROM FORMULARY
(NOT APPLICABLE FOR FORMULARY ADDITIONS OR CHANGES TO FORMULARY RESTRICTIONS)

REMOVAL FOR A SPECIFIC INDICATION ☐ COMPLETE REMOVAL FROM GGC FORMULARY ☐

CHANGE IN NATIONAL TREATMENT GUIDELINES (PROVIDE DETAILS BELOW) : ☐

CHANGE IN LOCAL TREATMENT PROTOCOLS (PROVIDE DETAILS BELOW) : ☐

CHANGE IN COST-EFFECTIVENESS OF TREATMENT CHOICES (PROVIDE DETAILS BELOW) : ☐

REMAINING FORMULARY TREATMENT CHOICES:

FURTHER DETAILS ON PROPOSED DELETIONS:

PLEASE PROVIDE THE FOLLOWING DETAILS FOR THE FORMULARY TREATMENT CHOICE WHICH YOU ANTICIPATE WILL REPLACE THE PROPOSED FORMULARY DELETION:

NAME OF TREATMENT OPTION:

COST OF TREATMENT PER PATIENT: £ **for a time period of**
e.g. 1 year, 28 days treatment, full course etc

ARE THERE ANY SERVICE IMPLICATIONS ASSOCIATED WITH THE USE OF THIS MEDICINE?
e.g. Diagnostic tests, monitoring, aseptic unit preparations etc

ESTIMATED NUMBER OF PATIENTS IN NHSGG&C TO RECEIVE THIS TREATMENT OVER A 1 YEAR PERIOD
Give details of numbers and area affected (e.g. 130 new patients/year in primary care or 20 patients per year as day case etc). Consider numbers for the whole of the health board rather than your own if possible.

SECTION 6: ADDITIONAL INFORMATION

USE THIS SECTION TO INCLUDE ANY FURTHER INFORMATION WHERE YOU HAVE NOT HAD SUFFICIENT SPACE IN THE OTHER SECTIONS:

Send the completed form, together with any supporting evidence, to:

FORMULARY TEAM
AREA MEDICINES INFORMATION CENTRE
GLASGOW ROYAL INFIRMARY
GLASGOW G4 0SF