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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-forms/) *before completing.*

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| **Medicine Information** |

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| Name of medicine | What is the name of the medicine you’d like to add to the formulary? |
|  |  |
| Formulation | Which formulation(s) of this medicine should be added? |
|  |  |
| Route of administration | What is the route of administration? |
|  |  |
| Proposed indication | What is the proposed 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. | | |
|  |  | | |
| 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)? | | |

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

|  |  |
| --- | --- |
| 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.

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| 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. |

* **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. |

**The applicant should return the form by email to** [**prescribing@nhslothian.scot.nhs.uk**](mailto:prescribing@nhslothian.scot.nhs.uk) **copying in the supporting Pharmacist.**

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| **Formulary Committee Decision (for internal use only)** |

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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. |
|  |  |
| Pharmacist name: | Enter pharmacist name here. |
|  |  |
| Date: | Select a date. |