STRICTLY PRIVATE AND CONFIDENTIAL APPLICATION FOR EXCEPTIONAL

FUNDING

**Proposed intervention/Drug:**

**THIS PAGE MUST BE COMPLETED FOR ALL EXCEPTIONAL DRUG REQUESTS. ALL APPLICATIONS MUST BE APPROVED BY YOUR TRUSTS DRUGS & THERAPEUTICS COMMITTEE BEFORE AN APPLICATION IS SUBMITTED TO THE ICB. APPLICABLE TO RUH & SFT ONLY.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **Patient Information** | | | | | | | | | | | | |
| **Name** |  | | | | | | | Male | |  | Female |  |
| **Address**  **Post Code** |  | | | | | | | | | | | |
| **Date of Birth** |  | | **NHS Number** | | | | |  | | | | |
| **B. Referrer’s Details (GP/Consultant/Clinician)** | | | | |  | | | | | | | |
| **Name** |  | | | | | | | | **Patient requested referral:** | | | |
| **Address**  **Post Code** |  | | | | | | | | | | | |
| **Telephone** |  | | | **Email** | |  | | | | | | |
| **GP Details (if not referrer)** | | | | | | | | | | | | |
| **Name** |  | **Practice** | | | | |  | | | | | |
| By submitting this form, you confirm that the information provided is, to the best of your knowledge, true and complete and that you have:   * Discussed all alternatives to this intervention with the patient * Had a conversation with the patient about the most significant benefits and risks of this intervention * Informed the patient that this intervention is only funded where criteria are met, or exceptionality demonstrated * Checked that the patient is happy to receive postal correspondence concerning their application where appropriate, or clarified alternative needs * Checked that the patient understands spoken and written English, or clarified required needs   I understand that it is a legal requirement for fully informed consent to be obtained from the patient (or a legitimate representative of the patient) prior to disclosure of their personal details for the purpose of a panel/IFR team to decide whether this application will be accepted, and treatment funded. By submitting this form, I confirm that the patient/representative has been informed of the details that will be shared for the purpose and consent has been given.  **Signed Referrer: .......................................................... Please also print name: ………………………………………….**  **Date: ……………………………….** | | | | | | | | | | | | |
| **Submission**  The completed form(s) should be sent electronically (from a nhs.net email address) in confidence with any other supporting documents to [BSWICB.EFR@nhs.net](mailto:BSWICB.EFR@nhs.net).  To **comply with information governance standards, emails containing identifiable patient data should only be sent securely, i.e., from an nhs.net account.** | | | | | | | | | | | | |

**THIS PAGE MUST BE COMPLETED FOR ALL REQUESTS**

**C. Treatment requested**

|  |
| --- |
| If applicant is from secondary care trust, has this application been approved by your trust’s drugs and therapeutics committee/chair or equivalent (not applicable for primary care applicants)?  YES NO Please note, if you have ticked NO the request will be rejected.  Y  YE |
| Nature of proposed treatment or intervention: |
| Brief history, including the patient’s current health status and any other health care problems: |
| Why do you consider this patient to have exceptional clinical circumstances? |
| Is there any other relevant information that should be considered? (e.g., clinical factors/co-morbidities/relevant personal circumstances) |
| What are the anticipated clinical benefits in this individual case of the treatment requested over other available options? |
| How will the benefits of the procedure/treatment be measured? What are the intended outcomes and how will these be determined? What ‘stopping’ criteria will be in place if the treatment is ineffective? BSW ICB will require regular feedback on the outcome if the treatment is approved: |

D. Costs

|  |  |
| --- | --- |
| Cost of treatment requested:  (For drug therapy – cycle and annual cost) |  |
| Details of any long-term cost implications and resultant needs that may be acquired from the proposed treatment: | |

E. Alternative Treatment Options

|  |  |  |
| --- | --- | --- |
| Provide a full list of treatments for condition that have been tried or considered, please include dates: | | |
| Date: | Intervention drug/surgery: | Reason for stopping/response achieved: |
|  |  |  |

F. Clinical Evidence

|  |
| --- |
| List of written supporting information – to include all relevant clinical details and copies of correspondence:  For example: GP Medical history record, extracts from Medical Records. |
|  |
|  |
|  |
|  |
|  |