

Cheshire and Merseyside Area Prescribing Group

Minor formulary amendment (form A)

This form should only be used for minor amendments to existing formulary drugs. Use form B for RAG designation changes and form C for new drugs or new uses of current drugs.

All forms should be completed electronically. Incomplete forms will be returned. Please list and include copies or hyperlinks to the references used in this application.

Please return completed forms to [apg@cheshireandmerseyside.nhs.uk](mailto:apg@cheshireandmerseyside.nhs.uk?subject=Minor%20formulary%20amendment).

In case of query please contact [apg@cheshireandmerseyside.nhs.uk](mailto:apg@cheshireandmerseyside.nhs.uk?subject=Minor%20formulary%20amendment%20query).

Cheshire and Merseyside Area Prescribing Group (CMAPG) will only consider applications submitted through local approval processes. Applications must be signed by appropriate sponsors from a relevant advisory or decision making groups. For drugs initiated in secondary care the sponsor must either be the Chair of the drugs and therapeutics committee or a medical director. For drugs initiated in primary care the sponsor must either be the Place medicines lead or medicines management group lead.

Forms completed by drug company representatives will not be accepted. It is important that applications represent the view of the sponsoring organisation rather than those of the manufacturer. The relevant directorate pharmacist or Place medicines lead will be able to provide information such as financial implications and formulation information.

The final decision may take up to eight weeks and will be communicated back to you directly.

## Application

### What is the purpose of this application?

Please summarise what change is required and why. What is the reason for this application?

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| --- |
| Click or tap here to enter text. |

## Medicine

### Generic name, brand name and manufacturer

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| --- |
| Click or tap here to enter text. |

### Formulation (e.g., tablets, capsules), strength and presentation (e.g., pack size, number of doses)

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| --- |
| Click or tap here to enter text. |

### Dose, frequency, course length (if applicable) and administration route

|  |
| --- |
| Click or tap here to enter text. |

### Licensed indication and proposed indication

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| --- |
| Click or tap here to enter text. |

## Appropriateness

### Current therapy prescribed for this indication

Please specify whether this will replace a current formulary medicine or be used in addition to current formulary medicines.

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| Click or tap here to enter text. |

### What clinical or patient benefits does this product offer over existing therapy?

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| --- |
| Click or tap here to enter text. |

### Additional background information

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| --- |
| Click or tap here to enter text. |

## Affordability

### What financial benefit does this product offer over existing therapy?

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| --- |
| Click or tap here to enter text. |

### Will there be an increased or decreased demand for other services?

For example, blood monitoring. If YES, please specify.

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| --- |
| Click or tap here to enter text. |

### How many patients will this be prescribed for once fully implemented?

Please liaise with all relevant organisations within the ICS to provide this information. Please note, depending on the application prescribing volume may be a more appropriate measure of impact. Please contact the subgroup chair to discuss.

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| --- |
| Click or tap here to enter text. |

### Any other costs and considerations?

|  |
| --- |
| Click or tap here to enter text. |

## Declarations of interest

### Applicant

|  |
| --- |
| Click or tap here to enter text. |

### Sponsor

|  |
| --- |
| Click or tap here to enter text. |

## Signatories

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Applicant’s name: Click or tap here to enter text. Date: Click or tap here to enter text.

Applicant’s job title, department or specialty: Click or tap here to enter text.

Sponsor’s name: Click or tap here to enter text. Date: Click or tap here to enter text.

Sponsor’s job title, department or specialty: Click or tap here to enter text.