CHI no .....
First name ..... DOB ....
Last name ..... Sex: ☐ M ☐ F
Address

or attach addressograph label here

Identifies as .....

Service/Hospitals/Dept. etc.
Ward/Team: .....

NHS Lanarkshire

Appendix 3 Prescribing Request to Primary Care for Unlicensed/High Risk Off-label Medicines

Dear Dr .....

Date: .... Time: .... (24 hour)

I would be obliged if you would prescribe the following for this patient	
Medicine:	Form:
Dose:	Frequency:
Indication:	

This request falls under the following General Medical Council (GMC) reason for prescribing an unlicensed medicine	
THERE IS NO SUITABLY LICENSED MEDICINE THAT WILL MEET THE PATIENT'S NEED	
i. Medicine is not licensed for the specific age of the patient but is licensed for the indication in other age groups	☐
ii. Medicine is not licensed for the specific age and for the specific indication but is licensed for other indications in that age group and for the indication in other age groups	☐
iii. The licensed dosage would not meet the patient's needs	☐
iv. The patient requires a formulation that is not available as a licensed product	☐
v. Other (specify)	☐

A SUITABLY LICENSED MEDICINE THAT WOULD MEET THE PATIENT'S NEED IS NOT AVAILABLE	
i. Temporary shortage of licensed medicine	☐
ii. No licensed formulation available in UK but is available for import from abroad	☐
iii. Medicine is at pre-marketing authorisation stage or has been discontinued and can be used for a named patient on compassionate grounds	☐
vi. Other (specify)	☐

PRESCRIBING FORMS PART OF A PROPERLY APPROVED RESEARCH PROJECT	☐

Evidence for use of medicine	
The unlicensed/off-label use of this medicine is described as an evidence based treatment option within established guidelines referenced below. *Quote Guideline(s) e.g. Scottish Intercollegiate Guidelines Network (SIGN), National Institute for Health and Care Excellence (NICE), British National Formulary (BNF), The Maudsley Prescribing Guidelines in Psychiatry, Scottish Palliative Care Guidelines, British Association of Dermatologists.*	☐
Treatment is not described in established guidelines, but relevant form (Appendix ☐1 or ☐2) has been completed and the appropriate approval received. *Final Approval by (ADTC, Senior Pharmacist* *References to relevant primary work*	☐

I consider this treatment necessary for the following reasons

Monitoring Arrangements	
Requirements:	Who will take responsibility for monitoring & where:
Frequency:	
Initial duration of medication trial:	Treatment review date:
Special precautions (if any)	

I have explained to the patient/patient representative that this treatment is unlicensed and the reasons for this and have attached a signed copy of consent.

Completed by: (PRINT NAME)	**Designation:**
Signature:	**Date:** .... **Time:** ....

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