**DECISION TO DECLINE PRESCRIBING OF MEDICINES RECOMMENDED BY HOSPITAL SPECIALISTS**

GP’s to complete this form if unable to assume responsibility of prescribing a medicine recommended by hospital specialist

**IMPORTANT** - If the form is to be emailed, it can  **only** be emailed from an  **NHS.net email** account to the appropriate  **NHS.net email**

account as listed below. Please **do not** use your personal (non NHS.net) account.

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| **Patient, Specialist & GP details** | | | | | | | | | | | | | |
| **Patient’s Name:** | | |  | | | | | | | **Date of Birth:** |  | | |
| **Hospital Number:** |  | | |
| **NHS Number** |  | | |
| **Specialist’s Name:** | | |  | | | | | | | **Name of GP:** |  | | |
| **Trust/ Site:** | | |  | | | | | | | **GP Practice:** |  | | |
| **Medication request details** | | | | | | | | | | | | | |
| **Name of drug**  Please fill in a separate form for each drug. | | | | | **Dose & frequency** | | | | | **Indication** | **Duration of treatment** | | **Date request received from secondary care** |
|  | | | | |  | | | | |  |  | |  |
|  | | | | |  | | | | |  |  | |  |
| **Reason for decision to decline prescribing** | | | | | | | | | | | | | |
| I have been asked to assume the responsibility / already have responsibility of prescribing the above drug/item for this patient.  Based on current local advice however, I am not / no longer in a position to do this for the reason(s) indicated b elow.  Prescribing should not be refused solely on the grounds of cost. Please contact your Prescribing Support Pharmacist for guidance.  *Suggestion*: - please attach a copy of the original letter requesting you to prescribe. Please tick most appropriate box (s). | | | | | | | | | | | | | |
|  | Unable to contact consultant for clarification **and** (please tick appropriate box(s) below) | | | | | | | | | | | | |
|  | Medicine is for ***hospital only*** prescribing and is in the RED list of products on the APC Formulary | | | | | | | | | | | | |
|  | Medicine is not in the APC Formulary (either rejected for inclusion or is a new drug not yet considered) | | | | | | | | | | | | |
|  | The APC Formulary states that a patient should be stabilised on the medicine before transfer to GP prescribing | | | | | | | | | | | | |
|  | Medicine requires regular specialist monitoring and requires specialist documentation such as a shared care document Effective Shared Care Agreement – (ESCA), Rationale for Initiation, Continuation and Discontinuation (RICaD) or similar which has not been supplied | | | | | | | | | | | | |
|  | Medicine is part of formal hospital-based clinical trial | | | | | | | | | | | | |
|  | Medicine is unlicensed and I am not sufficiently familiar with it to accept clinical responsibility | | | | | | | | | | | | |
|  | Medicine dose/indication is off-label and I am not sufficiently familiar with it to accept clinical responsibility | | | | | | | | | | | | |
|  | Medicine is not to be prescribed on the NHS | | | | | | | | | | | | |
|  | Item is an appliance or nutritional supplement and the patient is able to purchase it over-the counter | | | | | | | | | | | | |
|  | Medication is commissioned by NHS England – Specialised Commissioning and is not suitable for shared care | | | | | | | | | | | | |
|  | Medication is not in line with NICE/Local/National clinical guidelines and/or the prescribing request is not in line with a NICE  technology appraisal | | | | | | | | | | | | |
|  | Medication is not the most cost-effective option | | | | | | | | | | | | |
|  | Other reason (please state) | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Actions requested by GP to Specialist –** | | | | **GP to complete** | | |  | | | | | | |
|  | No further action required. I have prescribed an alternative or advised the patient to purchase the item.  Please state alternative:- Drug name Strength Dose | | | | | | | | | | | | |
|  | Please recommend APC Formulary alternative and/or supply further information (e.g. shared care document) | | | | | | | | | | | | |
|  | Please resume prescribing of this item and arrange appropriate follow-up as required | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **GP Signature** | |  | | | | **GP practice** | | |  | | | **Date** |  |
| [Blank] CCG   B’Ham South Central CCG  | | | | | | | | | | [Blank] CCG   Solihull CCG  | | | |
|  | | | | | | | | | | | | | |
| **GPs - please send this form to** | | | | | | | | | | | | | |
| **[Blank] NHS Trust:**  **[Blank]** [@nhs.net](mailto:christopher.anton@nhs.net) | | | | | | | | **[Blank] NHS Trust:**  [**[Blank]**@nhs.net](mailto:uhb-tr.PriorApprovals@nhs.net) | | | | | |
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| Please send a copy to your Practice Support Pharmacist. You are also advised to keep a copy in the patient’s records | | | | | | | | | | | | | |