**Specialist / Non-approved / Non-Formulary Medicines – Information for Patients**

Patient Name:        NHS number:        Date:

I have received a request from your hospital specialist        to prescribe       .

**I am contacting your hospital specialist to advise them I am unable to prescribe this medicine for you for the reason(s) stated below:**

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| Reason(s) that apply are ticked |
|  | It is a specialist medicine recommended for prescribing by hospital specialists only (see separate patient information leaflet for further information). |
|  | It is a specialist medicine, dose, duration or use for which I do not have the necessary prescribing information, experience or knowledge to accept responsibility for prescribing. |
|  | The medicine requires specialist monitoring and I have not been provided with adequate information about the monitoring required to accept responsibility for prescribing. |
|  | The majority of care and monitoring for your condition is provided by the hospital and so they also need to provide ongoing prescriptions for this medicine. |
|  | You are in a drug trial for this medicine and it is the responsibility of the hospital to provide ongoing prescriptions for this medicine. |
|  | Your condition is not stable and it is therefore the responsibility of the hospital to provide ongoing prescriptions for this medicine. |
|  | This medicine should be started by a specialist, and you should be stabilised on this medication before I am able to continue to prescribe |
|  | The request is for an unlicenced use of this medicine, and which should therefore be prescribed by a specialist able to take appropriate clinical responsibility |

**AND/OR**

|  |  |
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|  | This is a new medicine and the first prescription for a new medicine should be provided by the hospital. |
|  | This medicine has not been approved for use in Hertfordshire and West Essex by the local Hertfordshire and West Essex Area Prescribing Committee. |
|  | This medicine appears not to be prescribed in line with recommendations from the Hertfordshire and West Essex by the local Hertfordshire and West Essex Area Prescribing Committee. |

**The specialist is required to take one of the following actions:**

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| Action required is ticked |
|  | Provide you with the first prescription for the new medicine. |
|  | Recommend to me a suitable alternative medicine approved for use in Hertfordshire and West Essex. |
|  | Provide me with information about the new medicine and the monitoring required. |
|  | Make the necessary arrangements for you to receive ongoing prescriptions and supplies for the new medicine from the hospital. |
|  | No action required, as in accordance with local / national guidelines I am providing you with a prescription for the following alternative medicine: |

When action from the specialist is required, if you have any questions or do not hear from them or the practice within      days of receiving this letter, you should contact their secretary in the first instance, or the practice if that is not possible.

**Other medicines you normally get on prescription will continue to be prescribed for you by the practice.**

Prescriber Name:        Practice Details: