**Specialist / Non-approved / Non-Formulary Medicines – GP response letter to Trusts**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient’s Name: |  | NHS No: |  |
| Hospital specialist |  | Hospital/Trust |  |
| Name of Drug |  | Indication |  |

**You have written to me asking me to prescribe the above treatment for this patient. I am unable to prescribe this medicine for the reason(s) stated below:**

|  |
| --- |
| Reason(s) that apply are ticked |
| ☐ | It is a specialist medicine recommended for prescribing by hospital specialists only. |
| ☐ | 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 the condition indicated is provided by the hospital and so they also need to provide ongoing prescriptions for this medicine. |
| ☐ | The patient is in a drug trial for this medicine and it is the responsibility of the hospital to provide ongoing prescriptions for this medicine. |
| ☐ | The patient’s 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 the patient 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 therefore should be prescribed by a specialist able to take appropriate clinical responsibility. |

**AND/OR**

|  |  |
| --- | --- |
| ☐ | This is a new medication and the first prescription 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 of the Hertfordshire and West Essex Area Prescribing Committee. |

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

|  |
| --- |
| Action required is ticked |
| ☐ | Provide the patient 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 the patient to receive ongoing prescriptions and supplies for the new medicine from the hospital. |
| ☐ | No action required, in accordance with local / national guidelines I am providing the patient with a prescription for the following alternative medicine: |

**Please contact me to confirm the action taken and/or if you wish to discuss further.**

GP Name: ..…………………… Practice Details: ……………………

GP Signature: …………………