HOSPITAL BASED PRESCRIPTION (HBP) APPLICATION FORM



**This form should be completed to provide the Drug and Therapeutics Sub Committee with information to allow consideration for approval of a Service to prescribe medicines via Hospital Based Prescriptions. For information regarding Hospital Based Prescriptions please read Procedure for Hospital Based Prescriptions for dispensing by Community Pharmacy.**

**Section 1: Background Information**

## Name and brief description of the Service:

**Hospital site(s) that will prescribe on HBP:**

**Outpatient area/speciality:**

**Responsible consultants(s):**

## Where possible detail the medicine(s) to be prescribed including brand and manufacturer if appropriate. Where it is not possible to detail a finite list of medicines, include a description of the patient group and the remit of the service in terms of prescribing.

**Completed by:**

GP/Consultant - Name, full postal address and email address:

Clinical Pharmacist - Name, full postal address and email address:

**Approved by:**

**Clinical Director - NAME, SIGNATURE, DATE:**

By signing this form, it is confirmation that this medicine in Lothian is clinically appropriate to be prescribed and supplied via a HBP form and that the necessary budget provision is in place and available if Drug and Therapeutics Committee approve the application.

**Site Lead Pharmacist - NAME, SIGNATURE, DATE:**

**a) Please estimate for ALL Lothian use:**

**Section 2:**

**Description of Service in Lothian and justification of the requirement for HBPs**

Number of patients to be treated by the service:

Number of new patients per annum:

Number of patients to be prescribed treatment with the medicine on HBP per annum:

**Are these medicine(s) currently supplied by primary care or secondary care, please specify:**

**………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………**

**If secondary care, please detail the number of patients currently prescribed these medicines and supplied from hospital pharmacies per annum:**

**Benefits and risks of supply via HBPs:**

**b) Please summarise in the boxes below how it is proposed that the medicine will be prescribed using HBPs in Lothian.**

**Please specify therapy, quantity supplied and course length to be prescribed on HBPs and why:**

Please include any useful appendices eg Nurse Non-Medical Prescribing Formularies

**Please specify the criteria for patient selection:**

**Reasons for using HBPs:**

Please include supporting explanatory notes or document.

**Section 3**

**Financial information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Financial Information for the use of [*insert generic (and Brand) name of medicine here*]in Lothian | | **No. of patients in Lothian eligible for treatment**  **per annum** | **Cost per annum (£) per patient** | **Cost per annum (£)**  **ALL patients** |
| **Secondary Care** | Lothian |  |  |  |
| Non-Lothian |  |  |  |
| Primary Care |  |  |  |
| **TOTAL NET COST:** | |  |  |  |
| **Other cost implications if supplied via HBP and not supplied by hospital pharmacy** | e.g. VAT |  |  |  |

**Approved by:**

**Chair of Paediatric Drug and Therapeutics Committee/ UHD Drug and Therapeutics Committee/ HSSMC Drug and Therapeutics Committee/ Cancer Therapy Advisory Committee (if applicable) -**

By signing this form, it is confirmation that it is clinically appropriate for this Service to prescribe and supply medicines as described above via the Hospital Based Prescription process.

**NAME:**

**SIGNATURE:**

**DATE:**

**A declaration of interest should be completed by each applicant as detailed in section 1 of this form. A common form is used by ADTC and all its subcommittees, as detailed in the ADTC procedure** [**Declarations of Interest: Applying the Principles of Good Business Conduct.**](http://www.nhslothian.scot.nhs.uk/OurOrganisation/BoardCommittees/Committees/ADTC/MedicinesGovernancePoliciesADTCPolicyStatements/Documents/ADTC%20Policy%20Statement%20Good%20Business%20Conduct%20FINAL%20August%202013.pdf) **Please include a completed form with HBP application.**

**Section 4: Declaration of Interests**

P**lease post the completed form and signed declaration of interests to relevant Professional Secretary of Drug and Therapeutics Sub Committee.**

***Note* This document is regularly reviewed with the aim of ensuring that it is as user- friendly as possible. Please email any comments on the documentation to** [**prescribing@nhslothian.scot.nhs.uk**](mailto:prescribing@nhslothian.scot.nhs.uk)