

**NON-CONTRACT ACTIVITY FUNDING REQUEST FORM\***

**PLEASE PROVIDE ALL THE INFORMATION REQUESTED TO AVOID DELAYS IN PROCESSING THE REQUEST**

**INCOMPLETE FORMS WILL BE RETURNED**

**\*Non-contract activity treatment funding requests apply ONLY where local or national guidance exists, or routinely funded by CCGs within the provider’s local health economy (including CSII pump renewals in adults and children ≥12 years, biologics)**

**Please note: IFRs, including Non-Contract Activity requests, should only be submitted for tariff-excluded (previously known as Payment by Results Excluded) High Cost Drugs and devices which are not included in the Drug Tariff.**

**If a drug or a device is included in the Drug Tariff and is prescribable in primary care, it is not appropriate for an IFR and will be rejected. This includes flash glucose monitoring (e.g. FreeStyle Libre). Applicants are advised to contact the relevant Medicines Management Lead directly to discuss such requests.**

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| **TREATMENT** | |
| 1. **Details of treatment for which funding is requested** | |
| Diagnosis |  |
| Treatment including dose where applicable |  |
| How will the treatment be given to the patient (e.g. oral, IV, SC etc.) |  |
| Is this a single treatment or part of a course? |  |
| If this is a course of treatment, what is the number of doses that will be given and at what intervals? |  |
| 1. **Anticipated start date –** **Clinically triaging requests can take up to 2-4 weeks (from the date received by the IFR administration team.) If the case is more urgent than this please give reasons:** | |
|  | |
| **SUPPORTING INFORMATION** | |
| 1. **Outline the clinical background** | |
| **Previous therapies in chronological order for the condition in question and reasons for stopping**   |  |  |  | | --- | --- | --- | | Treatment and dose if applicable | Date started and date stopped | Reason/s for stopping | |  |  |  | |  |  |  | |  |  |  | |  |  |  |   Continue if necessary by inserting more rows above  **How is your patient currently being managed?**   |  |  |  | | --- | --- | --- | | Treatment | Date started | Clinical response to date | |  |  |  |   **Anticipated prognosis if treatment requested is not approved (include how the patient will be managed)** | |

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| **EVIDENCE OF CLINICAL AND COST EFFECTIVENESS/SAFETY** |
| 1. **Is the treatment licensed in the UK for the intended use?** |
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| 1. **Outline how the patient meets local or national guidance (include any objective parameters e.g. DAS28, PSARC, PASI, DLQI, etc with dates).** 2. **For insulin pumps and CGM systems include name of pump or CGM system, HbA1c, frequency, nature and management of any hypoglycaemic episodes with dates).** 3. **Include reference to the supporting local or national guidance.** |
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| 1. **What stopping criteria are in place to decide when treatment is ineffective?** |
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| **AFFORDABILITY** |
| 1. **What is the cost of the treatment** |
| |  |  | | --- | --- | | **Drug/ device** | Per annum **ex VAT** | | **Administration cost of treatment** | Per dose administered | | Frequency per annum | | **Home care costs** | Per delivery | | Frequency per annum | | **Follow up costs** | Per OPD attendance | | Frequency per annum | | **Consumables** | Per annum **ex VAT** | |
| **OTHER** |
| 1. **Clinicians are required to disclose all material facts as part of the process. Are there any other comments/considerations that are appropriate to bring to the attention of the IFR clinical triage team?** |
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| **CONTACT DETAILS** | |
| **Referrer details** | |
| **Trust address:** | |
| **Name:** | |
| **Designation:** | |
| **Contact phone number:** | |
| **Email: (NHS.net mail)** | |
| **Patient details** | |
| **Name:** | |
| **Address:** | |
| **DOB:** | |
| **NHS Number:** | |
| **GP Practice:** | |
| **CONSENT** |
| **I confirm that this IFR has been discussed in full with the patient. The patient is aware that they are consenting for the IFR Team to access confidential clinical information held by clinical staff involved with their care about them as a patient to enable full consideration of this funding request.** |
| **YES/NO**  **Please note without patient consent application cannot be processed.**  **Signature of Referrer: Date:** |
| **COMPLETED FUNDING REQUEST FORMS SHOULD BE RETURNED TO:** |
| **For Cheshire and Merseyside patients, email to the dedicated email below from a secure email account e.g. nhs.net:**  [ifr.manager@nhs.net](mailto:ifr.manager@nhs.net)    **In the event that you are unable to forward the application from a secure email address, the application can be posted to:**  CONFIDENTIAL  1829 Building – Mail Account  Facilities Services  Individual Funding Request Team  Countess of Chester Hospital NHS Foundation Trust  Liverpool Road  CHESTER  Cheshire  CH2 1UL |
| **COMMUNICATION OF DECISION OUTCOME** |
| **Decisions are routinely communicated to the named person stated in ‘referrer details’ i.e. the clinician taking overall clinical responsibility for the requested treatment. If another healthcare professional for the purpose of patient care requires a copy of the decision outcome correspondence, e.g. senior Trust pharmacist this can be facilitated on provision of a valid nhs.net address.** |
| **Name:** | |
| **Designation:** | |
| **NHS.net email:** | |