

INDIVIDUAL FUNDING REQUEST (IFR) FORM FOR DRUG REQUESTS

**PLEASE PROVIDE ALL THE INFORMATION REQUESTED TO AVOID DELAYS IN PROCESSING THE REQUEST
INCOMPLETE FORMS WILL BE RETURNED**

**ALL REQUESTS MUST BE APPROVED BY THE TRUST DTC/MMC CHAIR OR CHIEF PHARMACIST PRIOR TO
SUBMISSION**

Name of DTC Chair / Chief pharmacist approving the IFR submission from the organisation	
Job Title	
Email and signature of DTC Chair/Chief Pharmacist	

TREATMENT

1. Details of treatment for which funding is requested	Drug	
	Dose	
	How will the treatment be given to the patient (e.g. oral, IV, SC etc)	
	Where will the treatment take place (e.g. OPD, day case, home, 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?	
	What is the total length of time of the proposed treatment?	
2. Patient diagnosis		
3. Anticipated start date	Processing requests can take up to 2-4 weeks (from the date received by the IFR team.) If the case is more urgent than this please state why:	

SUPPORTING INFORMATION

<p>4. Clinical background</p>	<p>Please provide all the information requested to avoid delays in processing this request</p> <p>Outline the clinical situation. Include:</p> <ol style="list-style-type: none"> 1. Previous therapies tried and what was the response, including intolerance, adverse effects. 2. Current treatment and response, including intolerance. 3. Current performance status and symptoms. 4. Anticipated prognosis if treatment requested is not funded (include what alternative treatment will be given).
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BALANCING THE INDIVIDUAL NEED FOR CARE WITH THE NEEDS OF THE COMMUNITY

<p>5. What is the estimated incidence and prevalence of the condition being treated?</p>	<p><u>Incidence</u>: state number of patients expected to have this condition per 100,000 population per year:</p> <p><u>Prevalence</u>: state the number of patients expected to have this condition per 100,000 population per year:</p> <p>Please provide references for the stated incidence & prevalence here and attach full text articles.</p> <p>How often would you expect to request this treatment for this condition at this stage of progression of the condition for a given size of population?</p>
<p>6. What are the exceptional clinical circumstances that make the standard intervention inappropriate for this patient?</p>	<p>To meet the definition of ‘exceptional clinical circumstances’ your patient must demonstrate that they are both:</p> <ol style="list-style-type: none"> 1. Significantly different clinically to the group of patients with the condition in question and at the same stage of progression of the condition. <p>AND</p> <ol style="list-style-type: none"> 2. Likely to gain significantly more clinical benefit than others in the group of patients with the condition in question and at the same stage of progression of the condition. <p>Please give your reasons:</p>

7. If the drug were to be funded for this patient on an individual basis, would the decision set a precedent for other requests?	

EVIDENCE OF CLINICAL AND COST EFFECTIVENESS/SAFETY

8. Is the drug licensed in the UK for the intended use?			
9. What is the evidence base for the clinical and cost effectiveness/safety of the drug?	Full published data, rather than abstracts must be submitted with the application. If none available please state with reasons:		
10. Is the requested intervention part of a current or planned national or international clinical trial or audit?	If YES include details (e.g. name of trial including name of the trial and its protocol).		
11. Summary of previous intervention(s) this patient has received for the condition *reasons for stopping may include: course completed no or poor response disease progression adverse effects/intolerance	Dates	Intervention (drug/surgery etc.)	Reason for stopping* / response achieved
12. What are the anticipated clinical benefits in this individual case of the particular treatment requested over other available options?			
13. Why are standard treatments (those available to other patients with this condition/stage of disease) not appropriate for this			

patient?	
14. How will the benefits of the drug intervention be measured?	
15. What are the intended outcomes and how will these be determined?	
16. What stopping criteria are in place to decide when treatment is ineffective?	

AFFORDABILITY

<p>17. What is the cost of the treatment and how does this compare with the cost of standard treatment it replaces? Please ensure you include all attributable costs that are connected to providing the treatment e.g. drug/administration/follow-up/diagnostics</p>	
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OTHER

<p>18. 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 Team?</p>	<p>Details:</p>
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PLEASE TURNOVER

CONTACT DETAILS

Referrer details	Trust address:
	Name:
	Designation:
	Contact phone number:
	Email: (NHS.net mail where possible)
Patient details	Name:
	Address:
	Date of Birth:
	NHS Number:
	GP Practice & Post Code:

CONSENT

<p>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.</p>	<p>YES/NO</p> <p>Please note without patient consent funding requests are unable to be reviewed. All personal information will be removed prior to the consideration by the IFR panel.</p>
	<p>Signature of Referrer: _____ Date: _____</p>

COMPLETED FUNDING REQUEST FORMS SHOULD BE RETURNED TO:

email:	ifr.manager@nhs.net
Tel/ Fax:	<p>Telephone Enquiries: 01244 385157</p> <p>Fax: 01244 470380</p>
Post:	<p>Midlands & Lancashire Commissioning Supporting Unit Individual Funding Request Team Customer Solutions Centre 1829 Building Countess of Chester Health Park Liverpool Road Chester CH2 1HJ</p>