NHS
Isle of Wight
Clinical Commissioning Group

INDIVIDUAL FUNDING REQUEST (IFR) - SECONDARY CARE USE

Please note it is the Clinician's responsibility to obtain patient consent to share this and all supporting materials with the IW CCG. All information will be used and stored in accordance with the data protection act. Photographic evidence, where appropriate, may be submitted separately using only the minimum data set (GP details, initials, DOB and NHS number) to ensure patient confidentiality

All sections are to be completed in requests from secondary care and specialist provider services. In recognition of the nature of requests from primary care those sections denoted by an asterisk ***(*)*** *are to be completed at the discretion of the requesting general practitioner.* ***The fields are expandable so please include as much as you need***

Trust / GP Surgery/ GP Code		
1. *Address* *GP Code*		
2. *Applicant Details*	***Name:***	
	Position/job title:	
	Tel:	
	Email:	
3. *Patient Details*	***Initials***	
	Hospital ID number:	
	NHS Number:	
	DoB:	
	Registered Consultant:	
	Registered GP name:	
	Referred by (other than GP):	
	Date of referral:	
4. *Application reviewed by Chief Pharmacist or nominated deputy (in the case of a drug intervention)*	***Name:***	
	Signature or email confirmation:	

STATEMENT CONFIRMING APPROPRIATENESS FOR CONSIDERATION AS AN IFR	
If it is foreseeable that there are one or more other patients within the local IW population who are or are likely to be in the same or similar clinical circumstances as the requesting patient in the same financial year, and who could reasonably be expected to benefit to the same or a similar degree from the requested treatment then the request should properly be considered as a request for a service development and inappropriate for consideration as an IFR except in the circumstances where all the similar patients are expected to be from the same family group, a situation which may arise in the context of a rare genetic disease.	
5. ***I confirm that it is not expected that there will be more than one patient from within the Local IW population who is or is likely to be in the same or similar clinical circumstances as the requesting patient in the same financial year and who could reasonably be expected to benefit to the same or a similar degree from the requested treatment unless similar patients are expected to be from the same family group*.**	*10. Tick box as appropriate* *11. □Yes* *12. □ No*

DIAGNOSIS AND PATIENT'S CURRENT CONDITION	
6. ***Patient Diagnosis*** *(for which intervention is requested)*	
6(a) What is the patient's clinical severity? (Where possible use standard scoring systems e.g. WHO, DAS scores, walk test, cardiac index etc.)	
6(b) Please summarise the current status of the patient in terms of quality of life, symptoms etc.	

INTERVENTION REQUESTED *(NB: Intervention refers to requested treatment, investigation, etc.)*

7. *Details of intervention (for which funding is requested).* ***If the intervention forms part of a regimen, please document the full regimen*** *(e.g. Drug X as part of regimen Y (consisting of drug V, drug W, drug X and drug Z).*	***Name*** *of intervention:*	
	Dose and frequency (*)*:*	
	Planned duration (*) *Of intervention:*	
	Route of administration (*)*:*	***(IV/SC/IM/oral)***
	Anticipated cost (inc VAT) or HRG tariff	
	Are there any offset costs? (*)	*Delete as appropriate:* ***Yes/No*** *(refer to pharmacy if required)*
	Describe the type and value of the offset costs (*)	

Regarding anticipated cost Acute Trusts to provide this from finance departments	***Funding difference being applied for (*)***	

8. Is requested intervention part of a clinical trial?	*Delete as appropriate: **Yes / No*** *If **Yes**, give details (e.g. name of trial, is it an MRC/National trial?)*		
	Is the drug funded through a clinical trial? *Delete as appropriate: **Yes / No***		
8(a) What would be the standard intervention at this stage?			
8(b) What would be the expected outcome from the standard intervention?			
8(c) What are the exceptional circumstances that make the standard intervention inappropriate for this patient?			
8(d) Please explain how this individual has an exceptional ability to benefit from the requested intervention over and above another individual with the same condition.			
8(e) If the requested intervention was not available what would your next planned intervention be?			
10. Summary of previous intervention(s) this patient has received for the condition. *Reasons for stopping may include (not exclusively):*	***Dates***	***Intervention (e.g. drug / surgery)***	***Reason for stopping / Response achieved***

▪ *Course completed* ▪ *No or poor response* ▪ *Disease progression* ▪ *Adverse effects/poorly tolerated*			
11. Anticipated start date	*Processing a request **usually takes up to 28 working days** from the date received by the IWCCG. If the case is more urgent than this, please state why:*		

EVIDENCE OF CLINICAL EFFECTIVENESS

12. Where the intervention is a drug / medicine is the requested drug / medicine licensed for the requested indication in the UK?	*Delete as appropriate: **Yes / No** (refer to pharmacy if required)*
*13. Has the Trust Drugs and Therapeutics Committee or equivalent Committee approved the requested intervention for use? (if drug or medical device) **(*)***	*Delete as appropriate: **Yes / No*** *If **No,** Committee Chair or Chief Pharmacist approved: **Yes / No***
14. *Give details of National or Local Guidelines / recommendations or other published data / evidence base supporting the use of the requested intervention for this condition? **(*)***	***PUBLISHED[1] trials / data** (Please forward papers / web links for peer-reviewed papers where available. **This needs to be supplied for all secondary care and specialist provider requests – the request will not be considered if these have not been included.**)*
14.(a) How will you monitor the clinical effectiveness of this intervention?	
14.(b) Detail the current status of the patient according to these measures.	
14.(c) What would you consider to be a successful outcome for this intervention in this patient?	

1 *Full published papers, rather than abstracts, should be submitted*

14.(d) What is the minimum time frame/course of treatment at which a clinical response can be assessed? (e.g. after a single course of treatment)	
15. What is the anticipated toxicity of the intervention for this patient?	
16. Are there any additional clinical factors of the patient that need to be considered not already included in 8c or 8d?	*Delete as appropriate:* ***Yes / No*** *If* ***Yes****, please give details:*
17. Has this patient been previously referred to the Panel for this procedure? If yes, please provide details	
18. Form completed by	***Name:***
	Signature or email confirmation:
	Date:

All applications should be made using the Individual Funding Request Application Form **and provide all the required information as outlined in the Funding Request Form**. The form should be completed electronically / typed – handwritten submissions may not be accepted.

Submissions should be sent (by post or email) to:

Postal Address
Individual Funding Request Administrator,
Isle of Wight Clinical Commissioning Group,
Building A, The Apex,
St Cross Business Park
Newport
Isle of Wight PO30 5XN

E:Mail:

IWCCG.Authorisation@nhs.net - if your email is an@nhs.net
IWCCG.Authorisation@iow.nhs.uk – if your email is an @iow.nhs.uk