Individual Funding Request (IFR) Application Form

The clinical applicant (primary, secondary, tertiary or other) completing this form is responsible for collating all information and relevant evidence, which may involve working with other clinicians, outside of your organisation, involved in this patient's care. All forms must be typed, acronyms / abbreviations must be written out in full and all fields must be completed (or N/A stated where a field is not applicable). Incomplete mandatory fields and hand-written forms will result in the form being returned and may cause delays to consideration for funding. Please refer to your Clinical Commissioning Group's (CCGs) IFR policy or team (details at bottom form if any further support is required

Anonymity – please ensure that in order to protect patient identity, apart from section A, the patient is not referred to by name or initials within the application form.

Before completing this form, please answer the following questions	
Is this drug or non-drug request for a treatment currently commissioned by NHS England? * *If **Yes**, then **STOP HERE** and refer to NHS England.*	**Yes** ☐ **No** ☐
Drug requests	
Is the requested intervention part of a clinical trial? ** *If **Yes**, **then STOP HERE.** This funding route is not appropriate. Please speak to your trust chief pharmacist regarding drug trials.*	**Yes** ☐ **No** ☐
Is the drug listed on the National Tariff excluded drug list and is for use in accordance with a NICE Technology Appraisal Guidance / locally commissioned pathway? ** *If **Yes**, **then STOP HERE.** This funding route is not appropriate. Please redirect to the appropriate High Cost Drug (HCD) team.*	**Yes** ☐ **No** ☐
Governance - Has the treatment been approved through the provider's clinical governance arrangements for the requested intervention for use? ** *If **No, then STOP HERE.** The application requires trust governance approval. Evidence **MUST** be supplied e.g. drug and therapeutic committee (DTC) minutes, a letter from the DTC Chairman, if Chairman's action has been taken.*	**Yes** ☐ **No** ☐
Non drug requests	
Does the intervention requested fall under an existing policy (Treatment Access Policy (TAP), Effective Commissioning Initiative (ECI), Policy of Limited Clinical Value / Effectiveness (POLCV/E), prior approval)? *** *If **Yes,** and this application is being submitted by a GP, please check whether your CCG provides a referral management, clinical assessment or prior approval service.*	**Yes** ☐ **No** ☐
Has this request already been declined by a referral management/clinical assessment centre or Prior Approval Service? *** *If **Yes**, and the patient does not meet local policy criteria then your application needs to explicitly explain why your patient is clinically exceptional or rare in section G.*	**Yes** ☐ **No** ☐
Governance - Has the medical device/ intervention been approved in accordance with Provider's clinical governance arrangements *** *If **No, then STOP HERE.** The application requires approval. Evidence **MUST** be supplied e.g. minutes of the governance meeting where approval was given.*	**Yes** ☐ **No** ☐

* Mandatory fields for all requests ** Mandatory fields for drug requests *** Mandatory fields for non-drug requests

Section A: Contact Information *		
1. Applicant details *The applicant should have clinical responsibility for this intervention for this patient for this specific clinical indication.* *Please ensure the declaration is signed and dated (section I)*	**Name** *	
	Designation/Job title *	
	Telephone *	
	nhs.net address *(no other emails accepted)* *	
2. Patient details	**Initials** *	
	NHS number *	
	Date of Birth (DoB) *	
	Patient address *	
	Registered consultant *	
	Registered GP name *	
	GP practice code *	
	CCG *	
	Date of referral *	

Section B: Diagnosis * *(Diagnosis refers to condition that the requested intervention will treat)*	
3. Patient diagnosis or condition *(for which the intervention is requested)* *	
4. Date of diagnosis and summary of any other relevant medical history *	
5. Does your patient have any other relevant diagnoses or co-morbidities? *If yes, please list* *	
6. **What is the patient's current quality of life (QoL)?** *Please summarise the current status of the patient in terms of their QoL for example performing activities of daily living (please note the IFR panel cannot take social factors into consideration)* *	
7. **What is the severity of the current clinical condition, in relation to this diagnosis?** *Please use standard scoring systems e.g. World Health Organisation (WHO), Disease Activity Score (DAS28), cardiac index or those applicable to the patient's clinical diagnosis. Please include interpretation of the score where applicable* *	

Section C: Intervention Requested *(Intervention refers to requested treatment, investigation, etc)*		
8. **Details of intervention** *(for which funding is requested)*	**Name of intervention** *If the intervention forms part of a drug 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)* *	
	Type of Intervention *	Drug ☐ Procedure ☐ Device ☐ Other ☐
	Planned duration of intervention *	
	Dose and frequency of drug **	
	Route of administration of drug **	
9. Anticipated time frames	Your request will be acknowledged within 5 working days of receipt. A funding decision **usually takes the IFR process up to 20 working days** from the date of receipt of a **full and accurately completed** application with copies of supporting clinical papers and completion of section I.	
	Is the case more urgent than this? *If the clinical decision needs to be made immediately on the basis of clinical urgency, the trust should proceed at its own financial risk and submit an IFR application retrospectively. The decision to treat in the event of immediate or life-threatening circumstances must be made in accordance with NHS approved provider (Trust) governance mechanisms* * **Yes** ☐ **No** ☐	
	If 'Yes' please state why this case is clinically urgent	
10. Provider name*		**Is this provider NHS commissioned?** * **Yes** ☐ **No** ☐ *If no, please explain why an NHS commissioned service is not appropriate*
11. Provider address *		

Section D: Comparison with Standard Commissioned Intervention	
12. What would be the standard intervention / management for this patient at this stage of their disease / condition? *	
13. What would be the expected outcome from the standard intervention for this patient? *	
14. What are the specific reasons that make the standard intervention inappropriate for this patient? *	

* Mandatory fields for all requests ** Mandatory fields for drug requests *** Mandatory fields for non-drug requests

Section E: Previous and Current Treatment/ Interventions				
15. Summary of all 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/ poorly tolerated (please detail nature of adverse effect/intolerance)* *Please add more lines if required*	**Start date**	**Stop date**	**Name of Intervention** *for drugs include name, dose and frequency of use*	**Response** *reason for stopping or indicate if still continuing*

Section F: Evidence for Effectiveness of Intervention Requested	
16. Is the requested intervention licensed for the requested indication in the UK? *	**Yes** ☐ **No** ☐

17. Evidence*

It is the applicant's responsibility to provide robust relevant and valid evidence to support the use of the intervention in this patient.

*All relevant evidence should be provided. Give details of national or local guidelines/ recommendations [e.g. National Institute of Clinical Excellent (NICE), Scottish Medicines Consortium (SMC), London (Cancer) New Drugs Group etc.] and/ or full published papers (rather than abstracts) supporting the use of the requested intervention for this condition, unless the application relates to the use of an intervention in a rare disease. Please include any available data on the use of this treatment by your unit including clinical audit data for rare diseases. Copies of key references **MUST** be provided.*

(a) What is the evidence that this intervention is likely to be effective in this type of patient? *	
(b) Details of National, Regional or Local Guidelines/ Recommendations *	
(c) What are the anticipated benefits?*	

18. Outcomes *

(a) What would you consider to be a successful outcome for this intervention in this patient? * *Include details of the parameters you intend to measure*	
(b) How and when will you monitor this? *	
(c) What is the minimum timeframe/ course of treatment at which a clinical response can be assessed? *	
(d) What criteria will be used to decide when the intervention is no longer effective? * *Include details of the parameters you intend to measure*	

19. What are most frequent anticipated adverse effects and what would their estimated frequency be? *	
20. Do the benefits outweigh the risks? If so in what way? *	
21. What are the likely consequences for this patient if funding is not approved? *	
22. What are the other treatment options for this patient if funding is not approved? *	

Section G: Statement of Exceptionality or Rarity		
23. On which basis are you making this request? *	☐ Exceptional clinical circumstances (please continue to question 24) ☐ Rarity of condition or presentation (please continue to question 25)	
24. If exceptionality, please describe why this patient's clinical circumstances are exceptional * *Give specific information in each section opposite to indicate how this patient is significantly different from the cohort of other patients with the same clinical condition*	(a) Please describe in detail how the clinical presentation of this patient differs from other patients with this condition	
	(b) Please describe why and how this patient might be expected to gain greater health benefit from this intervention compared to other patients with this condition	
25. If rarity, please describe why this patient's condition or clinical presentation is so rare or unusual that there is no relevant commissioning arrangement in place *	(a) Please state the UK prevalence and quote the source/reference	UK prevalence: Ref:
	(b) Please describe how the clinical presentation of this patient makes them rare *	
	(c) Please state, how many patients with the same condition or presentation as this patient does your trust / practice expect to see in the next 12 months? *	

Section H: Costs and Review for Drug or Non Drug Interventions *(to be completed by approved NHS provider Chief Pharmacist or Service Manager)* *	
26. Total acquisition cost (inc VAT) for duration of treatment being applied for *and associated costs such as administering a drug, phlebotomy, activity etc* *	
27. State the value of any offset costs *	
28. Please benchmark these costs against London procurement contract prices *	
29. Application reviewed by chief pharmacist / service manager or nominated authorised deputy *	**Name:**
	Signature and email confirmation *:

SECTION I: APPLICANT'S DECLARATION *		
30. Declaration * I declare that this application is complete and accurate and that all necessary supporting information and evidence has been provided on this form (and attachments)		**Yes** ☐ **No** ☐
31. Patient consent * I confirm that the patient has given their explicit consent for their patient identifiable data to be shared with the following organisations in order to facilitate their funding request; the patient's host CCG, CSU staff, GP surgery and other clinicians and their organisation named in this form, along with any sub-contractors (who are directly involved in providing or planning my care). The sharing of this information is necessary in order to enable full consideration of this request. In the case of a minor or vulnerable adult, I confirm I have complied with the relevant legislation guidance and for people who are approving on the patient's behalf, the consent has been lawfully obtained in accordance with the Children Act 2004 and / or Mental Capacity Act 2005.		**Yes** ☐ **No** ☐ **Clinical applicants name and job title**:
32. Correspondence and Contact * The IFR team will copy the patient into correspondence concerning progress and outcome of their application. If you do not want the patient to be contacted or to receive correspondence please indicate this.		**Please copy the patient into correspondence. *** **Yes** ☐ **No** ☐
Responsible clinician name: *	**Signature or email confirmation: ***	**Date: *** **DD/MM/YY**

Forward application to the IFR team (via Trust Service Agreements Department or equivalent, if applicable).

For SW London CCGs: Croydon, Kingston, Merton, Sutton, Richmond and Wandsworth

Forms should be submitted to nelcsu.ifrswlondon@nhs.net Tel. enquiries: 020 3668 1222

For SE London CCGs: Lewisham, Bexley, Greenwich, Southwark and Lambeth

Forms should be submitted to: nelcsu.selifr@nhs.net Tel. enquiries: 020 3049 4154

Patient Equality Monitoring Data *

NEL IFR wants to live up to the standards set out in its Equality and Diversity policy and to meet its legal obligations in respect of age, disability, gender, gender re-assignment, marriage/civil partnership, pregnancy and maternity, race or ethnic origin, religion or belief and sexual orientation.

We need your help and co-operation to enable us to do this. By providing this information you are helping us to ensure that our policies and practices do not discriminate. The information you provide will be treated in the strictest confidence, it will be separated from your application form prior to consideration by the IFR Panel.

Information unavailable ☐
Prefer not to disclose ☐

1	**Ethnic Origin**				
	White	British ☐	Irish ☐	Any other White background ☐	
	Mixed	White and Black Caribbean ☐	White and Black African ☐	White and Asian ☐	Any other Mixed background ☐
	Asian or Asian British	Indian ☐	Pakistani ☐	Bangladeshi ☐	Any other Asian background ☐
	Black or Black British	Caribbean ☐	African ☐	Any other Black background ☐	
	Other Ethnic Groups	Chinese ☐	Any other ethnic group ☐		
2	**Sex**				
	Male ☐	Female ☐	Transgender ☐	Not disclosed ☐	
3	**Sexuality**				
	Heterosexual ☐	Bisexual ☐	Gay ☐	Lesbian ☐	
	Not disclosed ☐				
4	**Age Group**				
	16-25 ☐	26-35 ☐	36-45 ☐	46-55 ☐	
	56-65 ☐	66+ ☐			
5	**Do you consider yourself to have a disability?**				
	Registered disabled ☐	Unregistered disabled ☐	Not disabled ☐		
	Nature of disability				
	Hearing impairment ☐	Speech impairment ☐	Mobility Impairment ☐	Age related impairment ☐	
	Visual impairment ☐	Learning disability ☐	Mental health ☐	Other ☐	

6	**Religion**			
	No religion ☐	Christian ☐	Buddhist ☐	Other ☐
	Hindu ☐	Jewish ☐	Muslim ☐	
7	**Gender Reassignment**			
	Has patient Under gone gender reassignment?	Yes ☐	No ☐	Not disclosed ☐
8	**Relationship Status**			
	Married/Civil Partnership ☐	Divorced ☐	Single ☐	Widowed ☐
	Not disclosed ☐			
9	**Pregnancy and maternity**			
	Is the patient Pregnant or Breastfeeding?	Yes ☐	No ☐	Not disclosed ☐
10	**Carers**			
	Is the patient a Carer?	Yes ☐	No ☐	Not disclosed ☐