Click here to access the guidelines/NICE algorithm

Funding Application for romiplostim for chronic idiopathic (immune) thrombocytopenic purpura NICE TA221, TA293
Please ensure you complete the patient consent section below and share the patient leaflet with your patient. We will return this form if the patient consent section is not complete - this may delay the decision making process.

FUNDING APPLICATION FOR			
Drug		Romiplostim	
Condition		Chronic Immune (idiopathic) Thrombocytopenic purpura	
Treatment start/review date:			
PATIENT & GP DETAIL			
Patient Initials:		**Patient age:**	
Patient NHS Number:		**Practice Postcode:**	
Patient Hospital No:		**GP Practice Code:**	
CCG:			
Prescription Method:	☐ Hospital ☐ Homecare		
CONSULTANT & TRUST DETAILS			
Consultant Name:	*		
Choose Prescriber:			
Prescriber Name:	*	**Prescriber Role:**	Consultant
Notification Email Address:	*	(NHS or secure email account ONLY)	
Contact Telephone Number:	*		
Requesting Trust:			

PATIENT CONSENT	
I confirm the patient has consented to sharing of personal and clinical information contained within this proforma with clinical staff involved in their care and for the CCG funding approval team, as part of the exceptional cases process or Group Prior Approval processes, to request further information, clarify data and communicate where applicable with the patient, and for future audit purposes.	☐ Yes ☐ No Please confirm the consent.
By submitting this request you are confirming that you have reviewed this request against the relevant policy and believe the patient meets the relevant threshold criteria or exceptionality criteria. You have fully explained to the patient the proposed treatment and they have consented to you raising this referral on their behalf.	☐ Yes ☐ No Please confirm the consent.
Please confirm that you have brought the CCG patient leaflet on the collection and use of patient data for the funding request process to the patient's attention: click here to access the leaflet 'Why we need to collect your personal confidential information and your rights'. The leaflet is also available on the following web page: https://lincolnshireccg.nhs.uk/library/your-health-1/why-we-need-to-collect-your-personal-confidential-information-and-your-rights/	☐ Yes ☐ No Please confirm the consent.

FUNDING CRITERIA

Only fully completed forms will be accepted by NHS Lincolnshire CCGs for consideration.

If the answer to any of these questions is **NO**, please consider if there are patient specific exceptional clinical circumstances demonstrated. If so, **a full exceptional case or individual funding request (IFR) form will need to be completed.**

NICE criteria according to: www.nice.org.uk/ta221 or www.nice.org.uk/ta293

Please indicate whether patient meets the following NICE criteria:	**Please complete/tick**
1. Please confirm the treatment is being instigated and monitored by a consultant haematologist.	☐ Yes ☐ No

	* Required
2. I can confirm that treatment will only be continued in accordance with NICE guidance.	☐ Yes ☐ No * Required
3. I can confirm that this patient is an adult with chronic idiopathic(immune) thrombocytopenic purpura (ITP)	☐ Yes ☐ No * Required
4. I can confirm that the patient: • Condition is refractory to standard active treatments and rescue therapies OR • has severe disease and a high risk of bleeding that needs frequent courses of rescue therapies of rescue therapies	☐ Yes ☐ No * Required

APPROVAL FOR SUBMISSION FOR FUNDING BY TRUST	
Form completed by Name	Date