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N&WICS - TA622 - Sotagliflozin with insulin - Type 1 diabetes

Before providing patient identifiable data on this form, please confirm that the patient (or in the case of a minor or vulnerable adult with the parent/legal guardian/carer) has given appropriate explicit consent for sensitive personal information on this form to be passed to the CCG and/or CSU for processing this funding request and validating subsequent invoices. Consent given: ☐

If there is more than one NICE-approved treatment available, a discussion between the responsible clinician and the patient has taken place about the advantages and disadvantages of the treatments available. This has taken into consideration therapeutic need and whether or not the patient is likely to adhere to treatment. The most appropriate, least expensive, will be chosen (taking into account administration costs, dosage and price per dose) unless an order of preference is stated in the TAs. ☐

Patient NHS No:	Trust:	Practice Name:
Patient Hospital No: <input type="text"/>	Consultant Making Request: <input type="text"/>	Practice Postcode:
Patient's Initials and DoB:		Practice Code:
Notification Email Address: <input type="text"/> (@NHS.net account ONLY)		Contact name & number: <input type="text"/>
Start date of requested treatment: <input type="text"/>	Provider: <input type="checkbox"/> Private <input type="checkbox"/> NHS Supplier: <input type="checkbox"/> Homecare <input type="checkbox"/> Hospital	Sub-Type: <input type="text"/> N/A <input type="checkbox"/> (if applicable)

By completing this form, you confirm that you intend to use the requested medicinal product described below as agreed in the local commissioning statement. Any requests which fall outside of this use will require an individual funding request (IFR).

For support regarding IFRs, please contact: norfolkicd@nhs.net

For support regarding the criteria listed below, please contact: norfolknontariff@nhs.net

Please indicate whether patient meets the following NICE criteria:	Please tick
1. Sotagliflozin with insulin is recommended as an option for treating type 1 diabetes in adults with a body mass index (BMI) of at least 27 kg/m ² , when insulin alone does not provide adequate glycaemic control despite optimal insulin therapy, only if: <ul style="list-style-type: none"> • sotagliflozin is given as one 200 mg tablet daily • they are on insulin doses of 0.5 units/kg of body weight/day or more and • they have completed a structured education programme that is evidence based, quality assured, delivered by trained educators and includes information about diabetic ketoacidosis, such as: <ul style="list-style-type: none"> • how to recognise its risk factors, signs and symptoms • how and when to monitor blood ketone levels • what actions to take for elevated blood ketones and • treatment is started and supervised by a consultant physician specialising in endocrinology and diabetes treatment, and haemoglobin A1c (HbA1c) levels are assessed after 6 months and regularly after this. 	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Stop sotagliflozin if there has not been a sustained improvement in glycaemic control (that is, a fall in HbA1c level of about 0.3% or 3 mmol/mol).	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. As per NICE guidance, treatment should normally be started with the least expensive drug (considering the dose required, price per dose and any additional administration costs). Please confirm that the choice of drug is considered the most cost-effective treatment for this individual patient, noting that alternative treatment options recommended by NICE may be lower in cost, including the use of biosimilar medications if applicable.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Where an alternative lower cost treatment is available and has not been tried by the patient, please confirm	

that the clinical rationale for prescribing has been included in the patients' medical record for the purpose of auditing.

I confirm that the patient meets the criteria for treatment

Name of person completing:

Contact Details:

Designation of person completing:

Date:

Trust Authorising Pharmacist

Name:

Date: