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N&WICS - TA177 - Alitretinoin - Severe chronic hand eczema

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="button" value="v"/> (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. Alitretinoin is recommended, within its licensed indication, as a treatment option for adults with severe chronic hand eczema that has not responded to potent topical corticosteroids if the person has: <ul style="list-style-type: none"> • severe disease, as defined by the physician's global assessment (PGA) and • a dermatology life quality index (DLQI) score of 15 or more. 	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Alitretinoin treatment should be stopped: <ul style="list-style-type: none"> • as soon as an adequate response (hands clear or almost clear) has been achieved or • if the eczema remains severe (as defined by the PGA) at 12 weeks or • if an adequate response (hands clear or almost clear) has not been achieved by 24 weeks. 	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Only dermatologists, or physicians with experience in both managing severe chronic hand eczema and the use of systemic retinoids, should start and monitor treatment with alitretinoin.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. When using the DLQI, healthcare professionals should take into account any physical, sensory or learning disabilities, or other communication difficulties that could affect the responses to the DLQI. In such cases, healthcare professionals should ensure that the DLQI continues to be a sufficiently accurate measure.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. 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.		
6. The product is being used as described by local commissioning position.		<input type="checkbox"/> Yes <input type="checkbox"/> No
I confirm that the patient meets the criteria for treatment		
Name of person completing:	<input type="text"/>	Contact Details: <input type="text"/>
Designation of person completing:	<input type="text"/>	Date: <input type="text"/>
Trust Authorising Pharmacist		
Name: <input type="text"/>		
Date: <input type="text"/>		