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N&WICS - TA688 - Selective internal radiation therapy TheraSphere - Hepatocellular carcinoma

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. The selective internal radiation therapy (SIRT) SIR-Spheres is recommended as an option for treating unresectable advanced hepatocellular carcinoma (HCC) in adults, only if: <ul style="list-style-type: none"> used for people with Child-Pugh grade A liver impairment when conventional transarterial therapies are inappropriate, and the company provides SIR-Spheres according to the commercial arrangement. 	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The SIRT TheraSphere is recommended as an option for treating unresectable advanced HCC in adults, only if: <ul style="list-style-type: none"> used for people with Child-Pugh grade A liver impairment when conventional transarterial therapies are inappropriate, and the company provides TheraSphere according to the commercial arrangement. 	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. The SIRT QuiremSpheres is not recommended for treating unresectable advanced HCC in adults.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. 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. 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. 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:

Contact Details:

Designation of person completing:

Date:

Trust Authorising Pharmacist

Name:

Date: