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N&WICS - TA425 - Nilotinib - Treating imatinib-resistant or intolerant chronic myeloid leukaemia

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="text"/> <input type="text"/> (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. Dasatinib and nilotinib are recommended as options for treating only chronic- or accelerated-phase Philadelphia-chromosome-positive chronic myeloid leukaemia in adults, if: <ul style="list-style-type: none"> • they cannot have imatinib, or their disease is imatinib-resistant and • the companies provide the drugs with the discounts agreed in the relevant patient access schemes. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. High-dose imatinib (that is, 600 mg in the chronic phase or 800 mg in the accelerated and blast-crisis phases) is not recommended for treating Philadelphia-chromosome-positive chronic myeloid leukaemia in adults whose disease is imatinib-resistant. | <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. 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 |
| 4. 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:

Date: