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N&WICS - TA188 - Somatropin - Growth failure (children)		
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:	**Consultant Making Request:**	**Practice Postcode:**
Patient's Initials and DoB:		**Practice Code:**
Notification Email Address: (@NHS.net account ONLY)		**Contact name & number:**
Start date of requested treatment:	**Provider:** ☐ Private ☐ NHS **Supplier:** ☐ Homecare ☐ Hospital	**Sub-Type:** N/A **(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. Somatropin (recombinant human growth hormone) is recommended as a treatment option for children with growth failure associated with any of the following conditions: • growth hormone deficiency • Turner syndrome • Prader–Willi syndrome • chronic renal insufficiency • born small for gestational age with subsequent growth failure at 4 years of age or later • short stature homeobox-containing gene (SHOX) deficiency.	☐ Yes ☐ No
2. Treatment with somatropin should always be initiated and monitored by a paediatrician with specialist expertise in managing growth hormone disorders in children. The choice of product should be made on an individual basis after informed discussion between the responsible clinician and the patient and/or their carer about the advantages and disadvantages of the products available, taking into consideration therapeutic need and the likelihood of adherence to treatment. If, after that discussion, more than one product is suitable, the least costly product should be chosen.	☐ Yes ☐ No
3. Treatment with somatropin should be discontinued if any of the following apply: • growth velocity increases less than 50% from baseline in the first year of treatment • final height is approached and growth velocity is less than 2 cm total growth in 1 year • there are insurmountable problems with adherence • final height is attained.In Prader–Willi syndrome evaluation of response to therapy should also consider	☐ Yes ☐ No

body composition.Treatment should not be discontinued by default. The decision to stop treatment should be made in consultation with the patient and/or carers either by: • a paediatrician with specialist expertise in managing growth hormone disorders in children, or • an adult endocrinologist, if care of the patient has been transferred from paediatric to adult services.	
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.	☐ Yes ☐ No

I confirm that the patient meets the criteria for treatment Name of person completing: Designation of person completing:	Contact Details: Date:
Trust Authorising Pharmacist Name: Date:	