

3. Request for cover in full for non-formulary medicine (Doctor to complete)

Please complete the table below where non-formulary medicine is prescribed for the treatment of CDL conditions and the request is for cover without co-payment. Please supply additional information and supporting documentation where appropriate, as to why the formulary medicine cannot be used by the patient, including details of treatment failure or adverse drug reactions where applicable.

Medicine name and strength	Quantity	Supporting information for the request

Previous medicine history

Medicine name and strength	Date treatment with this medicine was initiated	How long did the patient use the medicine for?	Details of treatment failure or adverse drug reactions

4. Doctor's details (Doctor to complete)

Name and surname

Practice number Speciality

Telephone

Email

The outcome of this application will be sent to you by email.

Doctor's signature

Date