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| **ChemoCare New Protocol/Regimen Request Form** | Page 1 of 4 |

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| --- | --- | --- | --- | --- | --- | --- |
| **Protocol or Regimen required (please tick and complete relevant boxes)** | | | | | | |
|  | Regimen | Regimen Name | |  | | |
|  | Protocol (see page 3 for details) | Protocol Name | |  | | |
| **Protocol / Regimen Information (please tick and complete relevant boxes)** | | | | | | |
|  | NON-TRIAL |  | TRIAL | EudraCT Number | |  |
| **Reference Document (please tick and complete relevant boxes)** | | | | | | |
|  | SWSCN | | |  | Clinical Trial |  |
|  | Other nationally recognised network protocol | | | |  | |
|  | Primary Reference Source  If attaching weblink please ensure full reference can be opened or pleaseattacha paper copy of the primary reference to this request form | | | | | |
|  | Other e.g. EAMS information | | | | | |

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| **Funding (please tick and complete relevant boxes)** | | | |
|  | Blueteq | | |
|  | NICE | NICE TA Reference |  |
|  | Cancer Drug Fund | | |
|  | Clinical Trial Funding | | |
|  | Routine Commissioning | | |
|  | Locally approved | | |
|  | EAMS | | |
|  | Compassionate use (from company) | | |
|  | “Not funded” Private patient use only | | |

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| **Supporting information** | |
| Does this replace an existing treatment? | **YES / NO** |
| If YES. Which? |  |
| Can this superseded treatment now be archived? | **YES / NO** |
| Approximately, how many patients a year do you expect to treat with this regimen? |  |

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| **Indication (please list all appropriate diagnoses for the above regimen)** | | | |
| Diagnosis- please use Chemocare disease tree | ICD-10 | Morphology | ICD-O-3 |
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| **Regimen schedule to follow primary reference source?** | | | | | **YES / NO** |
| **This table MUST be completed if differs from primary reference source** | | | | | |
| SACT Drug | Dose | Days | Route | Cycle frequency | Cycle number(s) |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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| **Licensed medications?**  **If NO please refer to Unlicensed Medicines Policy on intranet** | | | | | **YES/ NO** |

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| **ChemoCare New Protocol/Regimen Request Form** | Page 3 of 4 |

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| **Supportive Meds (please tick if appropriate to build into protocol)** | | | |
|  | Antibiotic cover (please specify) |  | PCP prophylaxis |
|  | Allopurinol |  | HSV prophylaxis |
|  | Antiemetics – Low |  | H2-antagonist |
|  | Antiemetics – Medium |  | Proton Pump Inhibitors |
|  | Antiemetics – High |  | VTE prophylaxis |
|  | Antiemetics – Very High |  | Others (please list below) |
|  | Antidiarrhoea (Loperamide) |  | |
|  | | | |

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| --- | --- | --- | --- | --- |
| **Critical tests required** | | | | **YES / NO** |
| **If YES tick which apply** | | | | |
|  | Hepatitis screen |  | ECHO 3 months | | |
|  | ePAF completed |  | Other | | |
|  | Register for irradiated bloods |  |  | | |
|  | Fit for Treatment- please indicate days required  (This is required if treatment is required on e.g. Day 1, 8 and 15 but patient is reviewed before treatment is given a go ahead) | | | | |

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| **ChemoCare New Protocol/Regimen Request Form** | Page 4 of 4 |

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| **Protocol layout**  Use the box below to provide a flow diagram detailing the required regimens/arms with appropriate review points (see Chemocare pharmacists if require assistance to complete) |
|  |

**Requested by:**

|  |  |
| --- | --- |
| **Print Name:** |  |
| **Job Title:** | Date: |

**Chemo subgroup approval:**

|  |  |
| --- | --- |
| **Print Name:** |  |
| **Job Title:** | Date: |

**Completed form to be sent to Marios Decatris, Chair of Chemo subgroup and Sue Watts Lead Pharmacist cancer services**