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| **USE OF QUTENZA PATCHES IN ADULTS for PERIPHERAL NEUROPATHIC PAIN IN NON-DIABETIC PATIENTS** |

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| **PRIOR APPROVAL REQUIRED** |

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| 1. **Patient Information** | | | | | | | | | | | |
| **Name** |  | | | | | | Male |  | | Female |  |
| **Address**  **Post Code** |  | | | | | | | | | | |
| **Date of Birth** |  | | **NHS Number** | | | |  | | | | |
| **B. Referrer’s Details (GP/Consultant/Clinician)** | | | | | | | | | | | |
| **Name** |  | | | | | | | | Patient requested | | |
| **Address**  **Post Code** |  | | | | | | | | | | |
| **Telephone** |  | | | **Email** |  | | | | | | |
| **GP Details (if not referrer)** | | | | | | | | | | | |
| **Name** |  | **Practice** | | | |  | | | | | |
| By submitting this form you confirm that the information provided is, to the best of your knowledge, true and complete and that you have:   * Discussed all alternatives to this intervention with the patient * Had a conversation with the patient about the most significant benefits and risks of this intervention * Informed the patient that this intervention is only funded where criteria are met or exceptionality demonstrated * Checked that the patient is happy to receive postal correspondence concerning their application where appropriate, or clarified alternative needs * Checked that the patient understands spoken and written English, or clarified required needs   I understand that it is a legal requirement for fully informed consent to be obtained from the patient (or a legitimate representative of the patient) prior to disclosure of their personal details for the purpose of a panel/IFR team to decide whether this application will be accepted and treatment funded. By submitting this form I confirm that the patient/representative has been informed of the details that will be shared for the aforementioned purpose and consent has been given.  **Signed …………………………………………………….. Date ……………………………………………………..** | | | | | | | | | | | |
| **Submission**  The completed form(s) should be sent electronically (from a nhs.net email address) in confidence with any other supporting documents to:  I**n order to comply with information governance standards, emails containing identifiable patient data should only be sent securely, i.e. from an nhs.net account.** | | | | | | | | | | | |

**THIS PAGE MUST BE COMPLETED FOR ALL REQUESTS**

**D. Clinical Criteria to be read in conjunction with the “Qutenza” Policy.**

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| **CLINICAL CRITERIA FOR QUTENZA** | |
| Patient with localised neuropathic pain which is not controlled by 1st to 3rd line medications on the maximum tolerated dose as per [NICE CG173](http://www.nice.org.uk/guidance/cg173) | **Yes  No** |
| **OR** | |
| Patient who are unable to fulfil work responsibilities due to side-effects of oral treatment options (e.g. heavy vehicle driver/machinery operator) | **Yes  No** |
| For all patients initiated on Qutenza treatment:   * A baseline Numeric Pain Rating Scale (NPRS) score will be recorded at the start of treatment and reviewed at each appointment. * A maximum of 2 patches may be applied per treatment. * Qutenza patches applied should not be applied more frequently than every 4 months. * A maximum of 3 treatment episodes with patches may be given. * If patients get <30% pain relief in their Numeric Pain Rating Scale (NPRS) score from baseline then the treatment must be stopped. | |

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| Supporting information must be provided with the application (Please document the evidence you are enclosing to support this request.? |

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| **D. Criteria not met:**  **Mitigating circumstances/reasons for applying if criteria not met, to include:** Medical History,  Allergies, Acute Medication, Repeat Medication. Minimum Data set |