Cambridgeshire & Peterborough Integrated Care System

NHS Cambridgeshire & Peterborough

Group Prior Approval – Funding Application for Exogen Bone Healing System for Non-Union Long Bone Fractures in Adults – Local Agreement

Please ensure you complete the patient consent section below and share the patient leaflet with your patient/parent. We will return this form if the patient consent section is not complete – this may delay the decision-making process.

Patient Consent	Delete as appropriate
I confirm that the patient (or in the case of a minor or vulnerable adult the parent, guardian, or legal carer) has given consent for the patient identifiable data on this form to be shared with the Exceptional Cases Team or Panel and the Integrated Care Board (ICB) Medicines Optimisation Team High-Cost Drug Validation Officers. This data may then be used: 1. In the interests of the care of the patient. 2. For clinical audit purposes. 3. To validate against subsequent invoices.	Yes, consent given. No, consent not given.
By submitting this form, you are confirming that you have reviewed this request against the relevant policy and believe the patient meets the relevant threshold criteria or exceptionality criteria. You have fully explained to the patient, parent, or legal guardian the proposed treatment and they have consented to you raising this referral on their behalf.	Enter date of request:
You have further explained to the patient, parent, or guardian, that should a more cost effective, clinically appropriate biosimilar or generic medicine become available, which fulfils the National Institute for Health and Care Excellence criteria and the Medicines and Healthcare products Regulatory Agency guidance, this is the treatment which will be provided.	Yes / No
Please confirm that you have brought the ICB patient leaflet on the collection and use of patient data for the funding request process to the patient's, parent's or legal guardians attention: access the leaflet 'Why we need to collect your personal confidential information and your rights'.	Yes / No

GPA Request – provider commissioning to complete.

Patient NHS Number:		**Patient Name and Address:**		**Patient Hospital Number:**	
Hospital Trust:		**Consultant requesting treatment (print name):**		**Consultants contact details:**	
GP Name:		**GP Practice Code:**		**Confirm patient status:**	NHS / Private / Overseas (Delete as appropriate)

The funding of EXOGEN® will be made available at the end of treatment when the outcomes in terms of success or failure are known and the form is completed and submitted to the ICB within **1 month of completion of treatment.**

For treatment failures, the provider will ensure that a reimbursement is obtained in accordance with the manufacturers "money back guarantee" arrangement; the ICB will not fund these patients.

Please indicate whether the patient meets the following NICE and/or Local criteria:	**Delete as appropriate**
1. Please confirm the treatment was instigated and monitored by an orthopaedic consultant or consultant radiologist and the appropriateness of Exogen® has been determined through agreement of two specialist non-union consultants.	Yes or No
2. Please confirm that treatment was given in accordance with the NICE guidance, local policy and in line with the manufacturers guidance.	Yes / No
3. Please confirm the patient was registered on the Exogen ® International Performance Program. State Purchaser Code:	Yes / No
4. Please confirm that the patient had a long bone fracture with non-union defined as failure to heal after 9 months and was **not** being treated for a delayed union fracture. **Note: Use of Exogen to treat long bone fractures with delayed union or any other indications are not commissioned Exogen is not indicated for use in fractures of the skull or vertebrae, or in children or adolescents because of their skeletal immaturity.**	Yes / No
5. Please confirm that the patient has used Exogen® in accordance with the Exogen® International Performance Program and has shown a minimum 90% adherence to treatment for a minimum of 120 days.	Yes / No
6. Please confirm that treatment was successful. Please state time to heal: Date treatment was completed:	Yes / No

Only fully completed forms will be accepted by NHS Cambridgeshire and Peterborough ICB for consideration.

If the answer to any of these questions is **no,** please consider if there are patient specific exceptional clinical circumstances demonstrated. If so, **a full exceptional case or individual funding request (IFR) form will need to be completed.** Please refer to the individual CSU/ICB Exceptional case/IFR policy for further details.

Form Completed by:

Email:

Cambridgeshire & Peterborough Integrated Care System

NHS Cambridgeshire & Peterborough

Date of completion:

This form is available in BlueTeq, and this platform should be used wherever possible.
Alternatively, please forward this form to us at cpicb.e-ifr@nhs.net via your internal processing team.

Revisions	Actioned By	Version	Summary of Changes	Ratified at CPJPG	Date
	TG	1.0	New form on acceptance of local agreement	Yes	Feb 2021
7/7/23	CM	1.0	Accessibility check and formatting amends	N/A	N/A