

Sativex® Pay-for-Responder Order Form for NHS Patients*

This form must be fully completed prior to the start of a patient's treatment with Sativex. Only one form to be completed per patient. If further information is required or to report an adverse event, please contact GW Pharmaceuticals Medical Information on +44 (0) 1223 238170 or e-mail at medinfo@gwpharm.com



Section 1. PATIENT DETAILS	please tick
I confirm this is a new Sativex patient within the licensed MS Spasticity indication for Sativex who has not previously received a free pack** of Sativex.	<input type="checkbox"/>
I understand the patient will receive 1 pack of Sativex via this scheme	<input type="checkbox"/>
<small>** 1 PACK = 3 x 10mls vial (90 doses per vial, 270 doses per pack)</small>	

Section 2. FUNDING OF SATIVEX	please tick
I confirm that ongoing funding has been approved at a local level for this patient (if they respond to Sativex)	<input type="checkbox"/>

Section 3. DELIVERY CONTACT AND ADDRESS
Pharmacy Name: _____
Pharmacy Address: _____
_____ Postcode: _____
Pharmacy Tel: _____
Pharmacy e-mail: _____

Section 4. TREATING CLINICIAN'S DETAILS AND CONFIRMATION
<p>I confirm that I am an authorised person within the hospital to sign this form. I confirm that we are claiming an initial pack of Sativex free of charge for the patient who is starting on Sativex for the first time and that the patient has not previously received a free pack of Sativex. I understand that the costs of any subsequent packs of Sativex for this patient will not be met by GW Pharmaceuticals and confirm that on-going funding has been secured as detailed in Section 2. This order is subject to GW Pharmaceuticals' standard conditions of sale and the terms and conditions of the GW Pharmaceuticals Pay-for-Responder scheme.</p> <p>As your details provided below are 'personal data' for the purposes of the Data Protection Act 2018, they will only be collected, kept and used for the purposes and duration of administering the Sativex Pay-for-Responder scheme, and not for any other purpose, and for this purpose may be shared in the UK within the GW Pharmaceuticals group and with our distributor, Alliance Healthcare (Distribution) Limited, who receives this request and sends the pack to the Pharmacy. Further information as to how GW Pharmaceuticals and Alliance Healthcare will process your personal data can be found at: https://www.gwpharm.co.uk/privacy-terms#priv or http://www.alliance-healthcare.co.uk/privacy-and-security.</p>
Clinician's Name: _____ Tel: _____
Signature: _____ Date: _____
Position held: _____
Hospital name: _____
Hospital address: _____
_____ Postcode: _____
Clinician's e-mail: _____



When complete, please e-mail to SativexPFR@skills-in-healthcare.co.uk or fax 0330 332 8126

*Please note that GW Pharmaceuticals has the right to refuse registration into the Pay-for-Responder scheme if any of the above terms and conditions are not met. GW Pharmaceuticals reserves the right to remove the scheme at any point.