Out of licence cancer drug or regimen

Funding request form

This form is to be used to request Bupa funding for your patient to receive cancer drugs that are not licensed in the UK for the condition being treated.

For us to accurately assess your request, you need to:

1. Complete this form in **FULL** including all relevant elements of the patient's current medical condition and medical history
2. Attach MDT notes (section 5)
3. Attach accompanying evidence (section 6)

at least three working days before the treatment is due to take place.

We're unable to assess funding based on incomplete forms or evidence. If we need to ask you for more information, this is likely to delay our funding decision and risks delaying your patient's treatment.

1. Patient's details

Title (please tick)	☐ Miss ☐ Mrs ☐ Ms ☐ Mr ☐ Dr ☐ Other (please state)
Patient's name	
Date of birth	D D M M Y Y Y Y
Bupa membership number	

2. Clinician's details

Name	
Bupa provider number	
Hospital name	
Phone number	
Email address	

3. Patient's medical information

Primary diagnosis | Stage of disease

Are there any metastases? ☐ Yes, please specify site below ☐ No

Are you treating? ☐ Primary tumour ☐ Metastases ☐ Side effects, please give details below

Current performance status (ECOG)

4. Drug(s) requested (including supporting drugs)

	Drug 1	Drug 2	Drug 3	Drug 4
Drug name				
Cycle length				
Number of cycles or until progression/ toxicity?				
Number of treatments per cycle				
Route of administration				
Dosage				
Setting				
Relevant gene expression/ hormone status				
Proposed start date				
Is this part of a compassionate use scheme?				

Bupa will only fund experimental drug treatment following use of an initial licenced treatment where available. What line of treatment is proposed?

What is this treatment's intent? ☐ Curative ☐ Palliative ☐ Neo-adjuvant ☐ Adjuvant

Outline previous therapies tried and the response

Explain what standard treatments are available to other patients (including on the NHS) with this condition or stage of disease and why these are not appropriate for this patient.

Will the patient be receiving any other SACT alongside any of the drugs above?

5. Multidisciplinary Team (MDT)

Has this regime been agreed by an MDT?	☐ Yes. Please provide notes and supportive evidence as described in section 6.	☐ No. Your patient's policy may require an MDT opinion for treatment to be funded.
Name of hospital where MDT was carried out		
MDT speciality area	Date of MDT	D D M M Y Y Y Y
If an MDT is not suitable to be carried out, please explain why		

6. Evidence base for the use of this treatment at the given indication*

Select 1 option at minimum

Does the proposed treatment have an EMA licence for the given indication?*	☐ Yes, please attach a copy of the evidence along with this form	☐ No
Is there an existing NHS guideline recommending the proposed treatment for the given indication*?	☐ Yes, please attach a copy of the evidence along with this form	☐ No
Is there an existing ESMO or NCCN guideline recommending the proposed treatment for the given indication* **that is supported by a published phase III study?**	☐ Yes, please attach a copy of the evidence along with this form	☐ No
Are there any published Phase III clinical trial results (not interim findings) confirming clinical efficacy?	☐ Yes, please attach a copy of the evidence along with this form	☐ No
Is the proposed treatment published on the EMA or EU Orphan Drug Register?	☐ Yes, please attach a copy of the evidence along with this form	☐ No

***Including disease stage, line of treatment and pharmacogenetic markers.**

7. Trials and compassionate use

Is there a registered clinical trial investigating the proposed treatment for which the patient would meet the inclusion criteria? ☐ Yes, please give details below ☐ No

8. Consultant's declaration

I understand that the clinical information I've supplied may be considered to be a medical report for insurance purposes. I confirm that my patient (or their legal representative) has given their permission for me to share this information and, where they've asked to review this information, they've been given an opportunity to do so before I submitted this form.

I confirm that the information that I have supplied is the full clinical picture required for this request, I have completed all fields and I will submit all relevant evidence correctly in accordance with Good Medical Practice (GMP) standards set out by the GMC.

Consultant's name

Date D D M M Y Y Y Y

General Medical Council number

9. Further information

Our customers' health insurance schemes may cover the cost of some cancer drugs that aren't licensed or drugs that we don't routinely fund in the UK. When assessing funding requests, we look at the strength and quality of the evidence of clinical effectiveness and the anticipated measurable outcomes. These outcomes may include improvements in overall survival, progression-free survival, clinical response, and adverse effects.

Please return this form to us by secure email to OncologyTeam@bupa.com

Please be aware that information you send to this email address may not be secure unless you send us your email through Egress Switch. For more information and to sign up for a free Egress Switch account, go to **https://switch.egress.com/ui/learn**. You won't be charged for sending secure emails to a Bupa email address using the Switch service.