**Area Prescribing and Medicine Optimisation Committee (APMOC):**

**Medicines Guideline / Pathway Approval Form**

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| --- |
| **Name of Medicine Guideline / Pathway** |
|  |
| **Is this a new guideline / pathway? (please delete as appropriate)** |  Yes / No |
| **Please state the reason this document is needed e.g. No national guideline, local adaptation of NICE pathway, to document locally agreed best practice** |
|  |
| **If guideline / pathway deviates from national guidance please state rationale** |
|  |
| **For updated documents clearly identify changes including reason for change** |
|  | **Previous version** | **Current version** | **Reason for change** |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |
|  |  |  |  |
| **Details of persons consulted during document development** (add extra lines as needed) |
|  | **Name** | **Role** | **Department** | **Organisation** |
| Lead author |  |  |  |  |
| Clinical contributor |  |  |  |  |
| Clinical contributor |  |  |  |  |
| Non-clinical contributor |  |  |  |  |
| Non-clinical contributor |  |  |  |  |
| **List committees or groups who have endorsed the document - include meeting date** |
|  |
| **Reference sources used in development of the guideline / pathway**  |
|  |
| **Has Remedy** [Referral Home (Remedy BNSSG ICB)](https://remedy.bnssg.icb.nhs.uk/) pathways pages **been checked and ensure alignment**  |
| If any difference in Remedy guidance please state actions takenRemedy pathways manager Vicky.Ryan@nhs.net |
| **Has environmental/ sustainability impact been considered (if applicable)** |
|  |
| **Has Health Inequalities been considered. Will the Guideline/ pathway impact on health inequalities (If yes, do local EIA, NB IF NICE an EIA should have already been completed)** |
|  |
| **What Monitoring will be done to review equity of access and/or adherence to guideline** |
|  |
| **How will the guideline/ pathway be communicated across all sectors?** |
|  |
| **Interface pharmacists confirm medications included are on the BNSSG Joint Formulary.**  | Name: |
| Date: |
| **Date approved by APMOC** |  |
| **Review date (usually 3 years, unless national or local change required)** |  |