POYC
PHARMACY OF YOUR CHOICE

Pharmacy Of Your Choice Unit
St. Luke's Square, G'Mangia
Email: scheduleV.poyc@gov.mt
Tel. No. 21 232424 / 22481800

ATOMOXETINE REQUEST FORM

Medicines Approval Section

PATIENT DETAILS

Patient's Name and Surname: _____

Date of Birth:_____ **I.D. Card No:** _____

Address:_____

Age:_____ **Tel/Mob No:**_____ **Date of application:** _____

SECTION A

Schedule V Condition:

☐ Chronic Psychiatric Disorders Starting in Childhood

SECTION B

Patients with ADHD with one of the following *(tick where appropriate)*:

☐	Methylphenidate is ineffective at the maximum tolerated dose*
☐	Intolerant to low or moderate doses of methylphenidate*
☐	Stimulant medication is contraindicated *(please tick the applicable contraindication/s below)* ☐ Diagnosis or history of severe and episodic (Type 1) Bipolar (affective) disorder (that is not well controlled) ☐ Diagnosis or history of severe depression, anorexia nervosa/anorexic disorders, suicidal tendencies, psychotic symptoms, severe mood disorders, mania, schizophrenia, psychopathic/borderline personality disorder. ☐ During treatment with non-selective, irreversible monoamine oxidase (MAO) inhibitors, or within a minimum of 14 days of discontinuing those drugs, due to risk of hypertensive crisis ☐ Glaucoma ☐ Hyperthyroidism or thyrotoxicosis ☐ Known sensitivity to methylphenidate or to any of the excipients present ☐ Phaechromocytoma ☐ Pre-existing cardiovascular disorders including severe hypertension, heart failure, arterial occlusive disease, angina, haemodynamically significant congenital heart disease, cardiomyopathies, myocardial infarction, potentially life-threatening arrhythmias and channelopathies (disorders caused by the dysfunction of ion channels) ☐ Pre-existing cerebrovascular disorders cerebral aneurysm, vascular abnormalities including vasculitis or stroke or known risk factors for cerebrovascular disorders ☐ Other. Kindly specify: _____

*** A copy of the Control Card for Narcotic/Psychotropic Drugs confirming methylphenidate preparation initial trials MUST be attached to the request.**

_____ _____

Signature of Consultant | Name in Block Letters and Medical Council Reg. Number

Date _____

For office use only:

Copy of Control card attached ☐

Approved ☐

Not Approved ☐

_____ _____ _____

Pharmacist's Signature | Name in Block Letters | Date

Kindly fill ALL required sections

Data Protection Statement

All personal data is required to provide you with health care services as necessary, and is processed in accordance with the Data Protection Act, and as permitted by law. Further information about your data can be obtained on request