	Unlicensed Medicines Declaration		Doc No	014.3
	Responsible Person Approval		Effective Date:	08-Oct-2025
	Name:	Ashish Jari	Review Date:	08-Oct-2026
	Date:	07-Oct-2025	Version No:	1.0
	Signature:	Signed copy on file	Page:	Page 1 of 2

SOP 014.3 Unlicensed Medicines Declaration

CUSTOMER DETAILS			
Customer Name			
Order Number		Order Date	

PRODUCT DETAILS		
Product name	Pack Size	Ordered Qty

DECLARATION FOR ORDERING UNLICENSED PRODUCTS


To be signed by person ordering (Tick which applies):

WHOLESALE DEALERS ONLY:

- We shall take reasonable steps to ensure that the unlicensed product is for use solely in dispensing in accordance with a prescription from a doctor, dentist or nurse or pharmacist independent prescriber or a supplementary prescriber and that the prescriber is aware of the unlicensed status of the product.
- I understand that this order is for an unlicensed product and that we will maintain records of onward supply.
- We shall ensure that this product is being ordered to meet the special needs of a patient for whom the clinical needs cannot be otherwise met. The special clinical need does not include reasons of cost, convenience, or operational needs.
- I confirm that measures are in place to only supply when a licensed alternative is either not available, or a licensed alternative is not able to meet the clinical needs of the patient.

ALL OTHER PHARMACIES, HOSPITALS, DOCTORS, DENTISTS, SUPPLEMENTARY OR INDEPENDENT PRESCRIBERS:

- I declare that the unlicensed product is for use solely in dispensing in accordance with a prescription from a doctor, dentist or nurse or pharmacist independent prescriber or a supplementary prescriber and that the prescriber is aware of the unlicensed status of the product.
- I understand that this order is for an Unlicensed product and that we will maintain records of onward supply. This product is being ordered to meet the special needs of a patient for whom the clinical needs cannot be otherwise met. The special clinical need does not include reasons of cost, convenience, or operational needs.

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I confirm that a licensed alternative is either not available, or a licensed alternative is not able to meet the clinical needs of the patient.

Name: _____ Date: _____

Signature: _____ Professional Registration no.: _____
(if applicable)

VERSION HISTORY

Version	Description of Change	Date Changed
1.0	New Appendix	07-Oct-2025