

## نموذج طلب دواء لدليل الأدوية بوزارة الصحة Formulary New Addition Request Form

### Instructions:

- The addition of new medication to the formulary must be requested by a consultant or a senior registrar ONLY.
- The request should be approved and signed by section head/Hospital director of the requesting physician.
- The requested medication must be discussed in the department meeting and attachment of meeting minutes is required. The regional P&T committee is responsible for assuring the completeness of the request.
- Incomplete request will be returned to the requesting region.
- A medication can be considered by the Pharmacy & Therapeutics Committee (PTC) only if the medication is registered in the kingdom of Saudi Arabia by SFDA or approved by any one of the countries/ regulating bodies: USA, UK, Canada and European Medicine agency (EMA).
- Approved request by Hospital Pharmacy & Therapeutic Committee (PTC) will be forwarded together with the department minutes to regional PTC (if available) or regional assistant director of therapeutic services in regional directorate of health affairs
- Drug evaluation by Regional Drug information center must be attached to any new medication addition request.

TO BE COMPLETED BY THE REQUESTOR
<b>I. DRUG DESCRIPTION:</b>
Generic (Scientific) Name:
Proprietary (Trade) Name:
Dosage Form:
Therapeutic Classification:
Manufacturer:
<b>II. SPECIFIC INDICATION AND DOSING:</b>
FDA, (others) Approved Indications:
FDA, (others) Recommended Dose and Approved Route of Administration:
Regulatory Bodies Approval Status:

**III. Rational For Addition To The Formulary:**

a) Please list drugs that are currently available in MOH formulary (P/NP) (drugs from the same therapeutic or different therapeutic class) that is/are used for the same indications

Medication	Indication	Therapeutic class

b) Comparison to Formulary agents including: therapeutic advantages over drugs currently on formulary/ safety advantages/ drugs that could be considered for deletion. Include published literature that supports your rational.

c) No# of patients anticipated to use this medication annually (at the level of MOH/region)

Clinic	No# of patients	Estimate duration of therapy

**IV. Disclosures of Potential Conflict of Interests**

A) Have you received research support, educational funding, professional meeting, or travel funding or other funding/ support from the manufacturer of this medication?

- Yes
- No

If yes, please Explain:

B) Are you involved in a research study or an evaluation of a drug samples of this medication?

- Yes
- No

If yes, please explain

C) Did the manufacturer or the manufacturer's representative assist in completing this form?

- Yes
- No

If yes, please explain

**V. Requestor information**

Requesting physician name	Department/ Specialty	Signature and date

**VI. Approvals**

Section Name	Head Name	Signature and Date
Hospital Director	Hospital Director's Signature	Date

Please, attach your department meeting minutes in which the requested medication was discussed and agreed upon

