وزارة الصحة
Ministry of Health

وكالة الخدمات العلاجية

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 an associate consultant ONLY.
- The request should be approved and signed by section head and the department chairman of the requesting consultant/associate consultant.
- The requested medication must be discussed in the department meeting and attachment of meeting minutes is required.
- 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 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 delivered together with the 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 request.

TO BE COMPLETED BY THE REQUESTOR
1. DRUG DESCRIPTION:
Generic Name:
Proprietary Name:
Dosage Form:
Therapeutic Classification:
Manufacturer:
2. SPECIFIC INDICATION AND DOSING:
FDA, (others) Approved Indications:

FDA,, (others) Recommended Dose and Approved Route of Administration:

Regulatory Bodies Approval Status:

☐ KSA ☐ EMEA ☐ Canada ☐ FDA

3. RATIONAL FOR ADDITION TO THE FORMULARY:

A. Please list drugs currently available in hospital formulary (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 do you anticipate using this medication annually

Clinic	No# of patients	Estimate duration of therapy

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4. 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:

5. REQUESTOR INFORMATION

Requesting physician name	Department/ Specialty	Signature and date

6. APPROVALS

Section Name	Head Name	Signature and Date
Department Name	**Chairman name**	**Signature and Date**

Please, attaché your department meeting minutes in regards to your requested medication