وزارة الصحة
Ministry of Health

وكالة الخدمات العلاجية

NON formulary **Request**

Hospital:	Name:	
Region:	Age:	
Unit:	Gender:	Weight:
Date:	Nationality:	Diagnosis:

REQUEST OF A NON- FORMULARY DRUG (For Single Patient and Single Drug Use Only)

General Information:

- Please read this form completely before filling it out, this form is only to be used when requesting procurement of non- formulary drug for an indication which is approved by the drug regulatory body in one of the following countries/ reference regulatory bodies: Kingdom of Saudi Arabia, USA, Canada, UK and EMA.
- The request of non-formulary drug must be used for regular patient care not for research purposes.
- Please fill all fields in details, kindly send completed form to Pharmacy Department in your respective hospital.
- Please forward the approved request to Regional Assistant Director of Therapeutic Services in Regional Directorate of Health Affairs.
- All reports, lab results and investigations made for the patient.
- If approved, please send the form to Deputy Minister for Therapeutic Services.

Oncology/Hematology requests:

- **please make sure to attach the following; any incomplete requests will be automatically rejected:**

  Copy of hospital tumor board recommendations.

Request Status:

◯ New ◯ Refill

I. MEDICATION DETAILS

Generic/Brand Name:

Licensed Indication (s)

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II. PATIENT SPECIFIC DETAILS
Present Medical Problems:
Pertinent Laboratory Data:
Present Medications:
Past Medical History/ Drug History:
Rational for using non-formulary drug (please include information on previously used treatment modalities which have failed)
III. REQUIERED INFORMATION REGARDING USE OF REQUETED DRUG **Please provide specific information as how this drug will be used in this patient as per the following:**
Dosage Regimen:
Duration of treatment:
Therapeutic monitoring parameters:
Adverse effects & their management:
Special precautions for this particular patient (if any)

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IV. REQUESTOR's DETAILS:	
Requesting Physician :	Department Chairman or Section Head:
Contact #:	Signature:
Signature:	Date:
V. FOR HOSPITAL USE ONLY:	
◯ Recommended ◯ Not recommended	◯ Recommended ◯ Not recommended
Director of Pharmacy:	Drug information pharmacist:
Date:	Date:
Justification:	
VI. APPROVALS	
◯ Approved ◯ Not Approved	◯ Approved ◯ Not Approved
Medical Director:	Hospital Director:
Date:	Date: