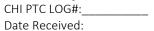
## **Pharmacy and Therapeutics Committee**





## INSURANCE DRUG FORMULARY ADDITION REQUEST FORM (Healthcare provider)

Addition of a dug/ Indication to insurance drug formulary may be requested only through a hospital Pharmacy and Therapeutic Committee or through the assigned medical director of polyclinics.. All information with supporting documents must be completed before the request is considered. Incomplete requests will be returned to the requesting entity.

## Complete the Following Information

1.	SFDA code:	
2.	Scientific name:	
3.	Brand name(s) with manufacturers names:	
4.	Strength:	
5.	Dosage form:	
6.	Therapeutic Class:	
7.	Indication:	Off label:
8.	List of all comparators:	
9.	ICD-10 code:	
10.	Indication listed in IDF:	□ Yes □ No
	1. Justification for additio	on request:



1	I. Are there any of indication(s) as the Yes	=		ce drug formulary which	are used for the same
2	2. If the answer of <b>(</b>	Question 2 is Yes,	please complete t	he following table:	
	Indication and	ICD-10-Am	Scientific Name	Drug Code	Therapeutic Class
а					
b					
c d					
<i>I</i> -fror <i>II</i> -fro	m meta —analysis or s m one or more RCT; om controlled trials	systematic reviev without random	v of randomized co	tion are defined as follows ontrolled trials (RCT's)/ lar se control, analytic studi	ge multi-center RCT's;
<i>IV</i> -fro	re and after studies ( om other observation om opinions of scien rt committees withir	nal studies; tific societies ba		research group); erience, descriptive studi	ies, or reports issued by
3		•	icacy of this drug d pharmacoecono	with alternative formu mics comparisons.	lary agents. Please use
-					
-					
-					
-					
_					



4. Summarize the comparative safety of this drug with alternative formulary agents.

Drug Name	Serious Reaction	%	Common Reaction	%	Occasional/Rare Reaction	%

	ist the main drug-drug interaction of this drug.
6. Li	st the contraindications/precautions for this drug.
7. L	ist any other potential advantages of this over current insurance drug formulary products.

**If yes**, please provide guidelines indicating patient selection criteria, dosage, monitoring parameters, duration of therapy, and criteria for discontinuation of the drug.



11. Should the prescribing	g of this drug be restricted to	certain members/subspecialty of the me	edical
staff?			
No □	Yes □ If yes, who	·	
		ives from the manufacturer of this drug?	)
No □	Yes 🗆		
•	•	n of drug samples of this drug?	
No □	Yes 🗆		
If the answer to quest	ions 12 and/ or 13 is yes, plea	se explain	
,		fthis drug addition request is approved?	If so,
,	letion of any formulary drug i and the reason for the propos		' If so,
,			' If so,
pecify name of the drug a	and the reason for the propos	ed deletion.	
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pecify name of the drug a	and the reason for the propos	ed deletion.	
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pecify name of the drug a	and the reason for the propos ced, state the reason(s) for n	ed deletion.  aintaining the current formulary produc	t.
pecify name of the drug a  .5. If no drug will be repla  .6. Hospital name:	and the reason for the propos ced, state the reason(s) for n	aintaining the current formulary produc	t.
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L5. If no drug will be repla	and the reason for the propos ced, state the reason(s) for n	aintaining the current formulary produc	t.
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pecify name of the drug a	ced, state the reason(s) for m	aintaining the current formulary produc	t.
Hospital name:  Email:	ced, state the reason(s) for m	aintaining the current formulary product	t.
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