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: □ Yes □ No Specific population:_____ Age: □Adult □Geriatrics □Pediatrics □ infants □Premature Gender: □ Male □Female □ both genders Setting: □ Inpatient □ Outpatient □ Daycare
8. List of all comparators:	
9. ICD-10 code:	
10. Indication listed in IDF:	□ Yes □ No

1. Justification for addition request:
_____
_____
_____
_____
_____

1. Are there any other drugs available in the insurance drug formulary which are used for the same indication(s) as the requested drug?
   Yes ☐ No ☐

2. If the answer of ***Question 2 is Yes***, please complete the following table:

Indication and	ICD-10-Am	Scientific Name	Drug Code	Therapeutic Class
a.				
b.				
c.				
d.				

- **Provide a copy of the supportive literature in the form of published studies in peer –reviewed journals and clinical practice guidelines if available. (Abstract presentations, and promotional literature by pharmaceutical companies are not acceptable).**

Levels of evidence for effectiveness of a healthcare intervention are defined as follows:
I-from meta –analysis or systematic review of randomized controlled trials (RCT's)/ large multi-center RCT's;
II-from one or more RCT;
III-from controlled trials without randomization; cohort, case control, analytic studies, multiple time series, before and after studies (preferably from than one center or research group);
IV-from other observational studies;
V-from opinions of scientific societies based on clinical experience, descriptive studies, or reports issued by expert committees within the field.

3. Summarize the comparative efficacy of this drug with alternative formulary agents. Please use evidence-based clinical studies and pharmacoeconomics comparisons.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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

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

5. List the main drug-drug interaction of this drug.

_____
_____
_____
_____

6. List the contraindications/precautions for this drug.

_____
_____
_____
_____

7. List any other potential advantages of this over current insurance drug formulary products.

_____
_____
_____

8. Common drug dosages:
   a) Adult:_____
   b) Children:_____

9. Should the prescribing of this drug be limited to a subgroup of patients with this condition?

□ No □ Yes

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

10 .What is the estimated usage per patient?[may indicate by treatment course, monthly or annually].

_____

_____

11. Should the prescribing of this drug be restricted to certain members/subspecialty of the medical staff?

No ☐ Yes ☐ If yes, who? _____

12. Have you received research support or other incentives from the manufacturer of this drug?

No ☐ Yes ☐

13. Are you involved in a research study or an evaluation of drug samples of this drug?

No ☐ Yes ☐

If the answer to questions 12 and/ or 13 is yes, please explain

_____

_____

_____

14. Do you suggest the deletion of any formulary drug if this drug addition request is approved? If so, specify name of the drug and the reason for the proposed deletion.

_____

_____

15. If no drug will be replaced, state the reason(s) for maintaining the current formulary product.

_____

_____

_____

Hospital name: _____

PTC Chairperson Name: _____ Tel: _____

Email: _____ Signature: _____ Date: ____/_____/_____

Polyclinic name:

Medical Director Name: _____ Tel: _____

Email: _____ Signature: _____ Date: ____/_____/_____

*Incomplete Form will not be accepted, Request must be typed.
Complete request to be submitted to IDF@chi.gov.sa