Request Form

1. 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

2. Justification for addition request:

_____
_____
_____
_____
_____

3. **Are there any other drugs available in the unified drug formulary which are used for the same indication(s) as the requested drug?**

   Yes☐ No☐

4. **If the answer of *Question 3 is Yes*, please complete the following table:**

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

a. 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.

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

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

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

7. **List the main drug-drug interaction of this drug.**

8. **List the contraindications/precautions for this drug.**

_____

_____

_____

9. **List any other potential advantages of this over current unified drug formulary products.**

_____

_____

_____

10. **Common drug dosages:**

a) Adult:_____

b) Children:_____

11. **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.

_____

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

_____

_____

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

No ▫ Yes ▫ If yes, who? _____

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

No ▫ Yes ▫

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

No ▫ Yes ▫

If the answer to questions 14 and/ or 15 is yes, please explain

_____

_____

_____

16. 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.

_____

_____

17. 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**: ___/_____/_____

If you have any questions regarding the application process, please email IDF@chi.gov.sa with the complete details of your question (s).

Incomplete Forms will not be accepted; all requests must be typed (PDF).