Kingdom of Saudi Arabia Ministry of Health **Hospital: ---------- Region: ----------** **Unit: ----------** **Date ----------**	Patient Number: _____ Name: _____ Bed No: _____ Age: _____ Gender _____ Weight:_____ 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 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 form to Regional Assistant Director of Therapeutic Services in Regional Directorate of Health Affairs.**
- **If approved, please send the form to Deputy Minister for Therapeutic Services.**

I. MEDICATION DETAILS

Generic/Brand Name:

Country where registered

Licensed Indication (s)

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)	
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: