UNITED ARAB EMIRATES
MINISTRY OF HEALTH

NON-FORMULARY DRUG REQUEST FORM FOR A SPECIFIC PATIENT

PART – A : PATIENT INFORMATION					
Medical Record #		Inpatient		Outpatient	
Name					
Date of Birth & Age					
Gender					
Nationality					
Contact #					

PART – B: REQUESTER INFORMATION			
Prescriber Name			
Specialty		Practicing License #	
Designation		Department	
Health Facility Name			
Medical District		Emirate	
Contact Phone #		Email ID	

PART – C: PHARMACEUTICAL & CLINICAL INFORMATION							
Request Status	New		Repeat		Refill		
Generic Name of the Requested Drug							
Dosage Form		Strength		Dose			
Route of Administration		Expected Duration of Treatment *(in days)*					
Urgency of the treatment required	Emergency *(Life Threatening Condition)*						
	Urgent *(24 – 48 hours)*						
	Soon *(7 -14 days)*						
	Non-urgent *(4 – 6 weeks)*						
Diagnosis/Indication							

Has the requested drug been approved for the above indication by the Regulatory Authorities?									
US-FDA		EMEA		MHRA		TGA		Others *(please specify)*	

Reason for Request	
	• Formulary options have been tried & failed
	• Patient experienced allergic reactions to formulary options
	• Patient experienced adverse drug reaction to the formulary options
	• Patient has contraindications to the formulary options
	• The requested drug is more cost effective than formulary options
	• Administration of the requested drug is more convenient in the current patient state
	• Hospital visit / stay can be minimized with the requested drug
	• Uninterrupted treatment cannot be made available to the patient for non-availability of the formulary options in our pharmacy facility
	• The requested non-formulary drug is an orphan drug for treatment of my patient's condition(s) for which formulary alternative is not available
	• Others: *(please specify)*……

Describe the expected outcome from the requested drug: ……
……..

Please mark Yes / No for the following	Yes	No
1. Is the requested non-formulary drug evidence based?		
If yes, attach relevant document(s)		
2. Has the requested drug been tried in the same patient before?		
If yes, what was the outcome? ……		
3. Has the requested drug been tried before by the same prescriber in any other patient within or outside the U.A.E.?		
If yes, what was the outcome? Attach details		
4. Does the requested drug have better efficacy than the formulary options? If yes, give evidence		
5. Does the requested drug have better safety profile than the formulary options? If yes, give evidence		

Source of information about the requested drug
How did you come to know about the requested drug?

	Company Medical representative *(please specify)*		Web Search *(please specify the site)*
	CME lectures *(please specify)*		Colleagues *(give details)*
	International Medical Journals *(please specify)*		Others *(please specify)*

History of Previous & Current Treatment with Formulary Options

Drug Name, Dosage Form, Strength & Route	Duration of Treatment	Reason therapy failed / discontinued
1.		
2.		
3.		
4.		

REQUESTER'S DECLARATION

I have been informed by …… *(Charge Pharmacist's name*) of possible formulary options to my non-formulary request and have determined that my non-formulary request is medically necessary for my patient. I am also aware of the possible delay in obtaining my non-formulary request.

The information given above regarding my patient, my non-formulary request, the given treatment and about myself are true to the best of my knowledge.

Signature with date & Full Name of the requester

Designation Stamp	Department Stamp	Health Facility Stamp

PATIENT'S DECLARATION

(to be signed by the patient if possible)

I, …… *(Patient's name)* have been under treatment of Dr…….. *(Requester's name)* for the aforesaid condition(s) since …… *(Treatment starting date)*. The treating doctor had tried the above medicine(s) in the patient for the stated ailment(s), but failed for the reason(s) stated above. I have been informed by the doctor about the new drug being requested for my treatment and I am aware of the delay in obtaining the requested drug.

Patient's Name, Signature & Date

(or otherwise by the bystander on patient's behalf)

My …… *(mention the relation)* Mr./Ms. …… *(Patient's name)* have been under treatment of Dr…….. *(Requester's name)* for the aforesaid condition(s) since …… *(Treatment starting date)*. The treating doctor had tried the above medicine(s) in the patient for the stated ailment(s), but failed for the reason(s) stated above. The patient has been informed by the doctor about the new drug being requested for the treatment and I am aware of the delay in obtaining the requested drug.

Bystander's Name, Signature & Date

Contact Phone #

IN-CHARGE PHARMACIST'S DECLARATION

I have clearly informed …….. *(Requester's name)* the possible formulary options for the requested non-formulary drug and possible delay in making the requested drug available to the patient. However, the requester has decided to continue with the request for the above non-formulary drug.

Signature with date & Full Name of the charge pharmacist

Contact Phone #		Email ID	

Designation Stamp	Department Stamp	Health Facility Stamp

PART – D : REQUEST REVIEW REPORT			
Please mark Yes / No for the following		Yes	No
1. Is there any formulary option other than those tried, but failed on the patient?			
2. Has the requested non-formulary drug been approved for the above indication by the following regulatory authorities?	US-FDA		
	EMEA		
	MHRA		
	TGA		
	Others (specify)		
3. Is the requested non-formulary drug superior to the formulary option(s) in efficacy and patient safety?			
4. Is the requested non-formulary drug registered with Registration & Drug Control Department of Ministry of Health, for the specified indication? 5. If yes, what is the estimated total cost of the requested treatment?			
6. Are the reason(s) stated by the requester evidence based?			
7. Is the requested drug cost effective compared to the formulary options?			

	Reviewer 1	Reviewer 2
Signature & Date		
Name		
Designation		
Department		
Department Stamp		

PART – E : DECISION			
Approved		**Not Approved**	
Reason(s) for the decision			

Signature & Date

Name:

Designation:

Office Stamp