



## PHYSICIAN DRUG ASSESSMENT QUESTIONNAIRE

Please complete the following questions accurately, and where applicable, provide as much details as possible. The information provided will be treated in the strictest confidence.

Proprietary Name of Drug:

Name of Active Ingredient:

Chronic Illness:

1. Do you prescribe this drug for your patients?      Yes       No
2. Approximately, how many of your patients with the above-mentioned chronic illness are being treated by this drug?  
Under 10       10 - 20       21 - 30       Over 30
3. How long have you been prescribing this drug?  
Less than 6 months       6-12 months       13-18 months       over 18 months
4. Are you satisfied with the overall clinical results observed with the use of this drug?  
Very satisfied       Satisfied       Fairly satisfied       Dissatisfied
5. If satisfied, what are the clinical advantages derived from prescribing this drug for your patients?

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6. What were the factors which influenced your choice of this drug in the treatment of the chronic illness? (Please select the box(es) that apply.)

- More effective than other drugs belonging to the same drug classification?
- More effective than other drugs belonging to a different drug classification?
- Better safety profile than other drugs
- Cost
- Patient profile for example, age, gender, existing co-morbid conditions
- Other

Please specify \_\_\_\_\_

7. How does this drug compare with other drugs belonging to the same drug classification, in terms of efficacy and adverse reactions, based on your clinical experience?

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8. How does this drug compare with other drugs that treat the same disease, but belong to different drug classifications, based on your clinical experience?

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9. How would you assess the safety profile of this drug among the majority of your patients taking this medication? Please select the appropriate box.

Highly tolerated       Moderately tolerated       Poorly tolerated

10. Would you recommend the addition of this drug to the NHF Programme?

Yes       No

Please indicate reason(s).

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### Declaration of Interest

Please put a “✓” in the appropriate box

I hereby declare that :

I have no personal or business interest, direct or indirect, in any matter that raises or may raise a conflict or potential conflict with my involvement in this process.

I have a personal and business interest, direct (e.g. family, directorship, etc.) or indirect, in this matter that raises or may raise a conflict or potential conflict with my involvement in this process.

The particulars of such matter are stated below :

\_\_\_\_\_  
Name of Doctor \_\_\_\_\_

Specialty \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Thank You for Your Participation.**