REQUEST FOR ADDITION OR REVISION OF MEDICATION FORMULARY FORM

This form must be completed by the requesting physician

Date Request:_____ Requesting Physician Name: _____

Department/Specialty: _____

Drug Information:

1. Generic Name: _____ 2. Brand Name: _____

3. Intended Use: _____

4. Form: _____ 5. Route: _____ 6. Dosage: _____

7. Adult Use: ☐ 8. Pediatric Use: ☐ 9. Both: ☐

10. Will drug be used off label? Y N

11. DEA Controlled Substance? Y N LASA? Y N

12. If so, does clinic meet all policy/protocol requirements? Y N

13. Medication will be administered by? _____

14. Any special precautions with medicatiom administration? If so, please list: _____

_____

15. Are there similar products on the formulary? If so, please list: _____

_____

16. Will new drug replace current formulary medication? If so, please list: _____

_____

_____

17. Reason for request (advantages over existing products): _____

_____

_____

18. Should the requested drug be restricted? If so, please list: _____

_____

19. Literature Citations: _____

_____

_____

20. Copyright issues to be considered or disclosed: _____

_____

21. Medical Director in agreement with the addition/revision of the medication formulary form? Y N N/A

22. Has the form been formatted with all the elements indicated in Policy 4.1? Y N

Comments:

_____ _____

Requestor Signature Date

_____ _____

Clinical Manager Signature Date

_____ _____

Clinical Medical Director/Department Chair Signature Date