SUNY DOWNSTATE Medical Center

Department of Pharmacy
450 Clarkson Avenue Box 6
Brooklyn, New York 11203

REQUEST FOR ADDITION TO THE FORMULARY

Date: ______________

Name of drug (generic): ______________________________

Brand Name: ______________________________

Dosage Form (tablet, ointment, injection.etc.): ______________________________

Strength(s): ______________________ Manufacturer: ______________________

AHFS#: ______________________________

Service requesting drug: ______________________________

List Advantages and Pharmacological actions: ______________________________

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What drug would this new agent replace on our formulary? ______________________________

Requesting Physician's Signature: ______________________________

Requesting Physician's Name & Extension (Please print): ______________________________

Department Chairperson's Signature: ______________________________

*****************************DO NOT WRITE BELOW THIS LINE********************************

TO BE COMPLETED BY PHARMACY ONLY

LIST COMPARABLE DRUGS IN HOSPITAL FORMULARY

NAME	MANUFACTURER	COST

Comments and Recommendations: ______________________________

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Propensity for medication errors: ______________________________

Abuse potential: ______________________________

Sentinel events observed or potential: ______________________________

Director of Pharmacy Signature: ______________________ Date: ______________

*****************************DO NOT WRITE BELOW THIS LINE********************************

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ACTION TAKEN:

- ❑ **Approved for Formulary Listing**
- ❑ **Restricted Approved (List Restrictions)**
- ❑ **Not Approved**
- ❑ **6 month review (Date:__________)**

Remarks: ______________________________

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Signature of Chairperson: ______________ **Date:** ______________