

# SUNY- UNIVERSITY HOSPITAL OF BROOKLYN FORMULARY ADDITION REQUEST FORM

*To Be Completed by the Requesting Attending Physician and Returned to the Director of Pharmacy at Box 36*

**I. Drug Description**

A. Generic name: \_\_\_\_\_

B. Brand or Proprietary name: \_\_\_\_\_

C. Dosage strength(s): \_\_\_\_\_

D. Dosage form(s) – (i.e. tablet, capsule, inj., susp.): \_\_\_\_\_

E. Manufacturer: \_\_\_\_\_

F. Medication Class & Mechanism of Action (describe unique pharmacologic properties, if any)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**II. Specific Indications & Dosing**

Indication	Dose	Specific Criteria
A.		1. 2. 3.
B.		1. 2. 3.
C.		1. 2. 3.

**III. Patient/Medication Safety Issues**

A. Sound alike/ Look alike names (generic or brand) \_\_\_\_\_

B. Abbreviations (potential or existing) \_\_\_\_\_

C. Packaging/Container design (similarities, storage) \_\_\_\_\_

D. Potential for improper dose/administration (dosage form, preparation, route) \_\_\_\_\_

E. Abuse Potential \_\_\_\_\_

F. Sentinel Event Potential/Observation \_\_\_\_\_

**IV. Monitoring Parameters**

**A.** What baseline tests and/or clinical parameters (e.g. LFT's, serum creatnine) are required to initiate therapy and monitor efficacy and/or toxicity of this product?:

Test/Parameter 1: \_\_\_\_\_ Frequency: \_\_\_\_\_

Test/Parameter 2: \_\_\_\_\_ Frequency: \_\_\_\_\_

Test/Parameter 3: \_\_\_\_\_ Frequency: \_\_\_\_\_

**B.** What is the therapeutic goal (include lab values, etc) with this product and expected duration of therapy?:

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**IV. Rationale for addition to formulary**

**A.** List all item(s) currently on the formulary that are similar to this product and state the advantages the requested item has over our current formulary product(s). Compare safety and efficacy:

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**B.** Should any current formulary item(s) be deleted if the requested product is accepted onto the UHB formulary? If yes, please list:

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**C.** Explain how the use of this drug would affect hospital costs and labor. This includes actual drug acquisition costs, hospitalization and logistical operations of drug preparation, distribution and administration:

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**D.** Please indicate the cost of this drug product based upon availability (i.e. -\$19.95 per bottle of 30 tablets ).

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**E.** How many patients do you anticipate using this medication annually?

<5 patients    5-20 patients    20-50 patients    50-100 patients    >100 patients (specify # : \_\_\_\_\_ )

**F.** Should this product be restricted to certain physicians or services because of field specific indications, high toxicity, or high cost? If yes, whom & why?: \_\_\_\_\_

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Pharmacy Use Only

Date P&T Committee Secretary/ Clinical Pharmacy Manager Received: \_\_\_\_\_

Date Clinical RPh Reviewer received: \_\_\_\_\_

Scheduled date of P&T Committee Review: \_\_\_\_\_

Acquisition Cost for Proposed Addition to the Formulary: \_\_\_\_\_

**ACTIONS TAKEN:**

\_\_\_\_\_ Approved for Formulary Addition

\_\_\_\_\_ Restricted Approval for Formulary Addition ( List Restrictions) \_\_\_\_\_

\_\_\_\_\_ Not Approved for Formulary Addition

\_\_\_\_\_ Six Month Review Date: \_\_\_\_\_

Signature of P&T Committee Chairperson : \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Director of Pharmacy: \_\_\_\_\_

Date: \_\_\_\_\_