SUNY- DOWNSTATE HEALTH SCIENCES UNIVERSITY FORMULARY ADDITION REQUEST FORM

To Be Completed by the Requesting Attending Physician and Signed by the Department Chair prior to submission to Pharmacy

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: _____

_____

G. Warnings/Contraindications: _____

_____

H. Affected Patient Population (Check all that applies): ❒ ALL ❒ Adults ❒ Pediatrics ❒ Neonates

I. Is it considered Potentially Inappropriate Medication (PIM) in elderly patients as per Beers List? ❒ Yes ❒ No

If yes, please explain: _____

J. Does this medication have a Risk Evaluation and Mitigation Strategy (REMS) program? ❒ Yes ❒ No

If yes, please check all that apply below:

- ❒ Level 1: Medication Guides and Patient Education
- ❒ Level 2: Active communication of risk to prescribers- letters, professional meetings
- ❒ Level 3: Element to Assure Safe Use (ETASU)
  - Health care providers who prescribe the drug have particular training or experience or are specially certified.
  - Pharmacies, practitioners, or health care settings that dispense the drug are specially certified.
  - The drug is dispensed to patients only in certain health care settings, such as hospitals.
  - The drug is dispensed to patients with evidence or other documentation of safe use conditions, such as laboratory test results.
  - Each patient using the drug is subject to certain monitoring.
  - Each patient using the drug is enrolled in a registry.

IV. Monitoring Parameters

A. What baseline tests and/or clinical parameters (e.g., LFTs, serum creatinine) 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?

_____

V. 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:

_____

_____

_____

_____

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

_____

_____

_____

_____

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:

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

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?

G. List and attach primary references other than reviews/editorials from the literature that will support your rationale for formulary addition:

1. _____

2. _____

3. _____

VI. Manufacturer & Financial Disclosures:

A. Do you have any affiliation or financial involvement with this drug or with its manufacturer, including any employment, consultancies, stock ownership, honoraria, support of research projects, or other educational support?
❒ Yes ❒ No If yes, please explain:_____

B. Have you or anyone in your department used this product as part of any research study, or have any experience with this product? ❒ Yes ❒ No If yes, please explain:_____

C. Did the manufacturer or the manufacturer's representative assist in completing this form? ❒ Yes ❒ No
If yes, please explain:_____

All drug requests are reviewed by the Pharmacy and Therapeutics Committee. Information from the attached form as well as a review of the literature and any guidelines provided by the requestor will be used as a basis for committee discussion. You will be notified as to when your request will be reviewed by the committee.

Requesting MD (Print)	*Signature*	*date*
Office phone or pager	*Division*	
Chairman of Division (print)	*Signature*	*date*
Chairman of Department (print)	*Signature*	*date*

Pharmacy Use Only

Date P&T Committee Secretary 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
  - o List Restrictions: _____

    _____

    _____
- ❒ Not Approved for Formulary Addition
- ❒ Used as Non-formulary
  - o Six-Month Review Date: _____

Implementation Date: _____

Signature of Director of Pharmacy: _____ Date:_____