

Pharmacy and Therapeutics Committee Formulary Change Form

This form is used to request modifications to the PHS entity formulary. Modifications may only be requested by attending faculty physicians or through needs identified by the Pharmacy Services. All portions of this form must be completed or it will be returned. Completed forms should be forwarded to: P&T Secretary, Pharmacy Services.

I. Formulary modification requested

_____ Addition _____ Deletion _____ Restriction

if you are requesting restriction, please provide conditions for restriction:

II. Drug information

- Generic name _____ Trade Name(s) _____
- Manufacturer(s): _____
- Mechanism of action: _____

- Usual dose, frequency, and duration of therapy: _____
- Anticipated monthly frequency of use. Please include number of patients, specify whether inpatients or outpatients or both, etc. _____
- Comparable drug(s) on formulary: _____

- Situations in which this drug is superior to those on formulary (attach additional sheets if necessary): _____
- Should we consider deleting any items from the Formulary because of this drug?: _____
- Special cautions and restrictions in use: _____
- Pertinent literature references (Please attach): _____

- Suggested criteria for use: (Please attach additional sheets if necessary):
 1. Guidelines: _____

 2. Monitoring parameters (including adverse drug reactions/interactions that may occur and preventive and/or responsive management for each): _____

 3. Outcome measures (markers to determine drug efficacy):

III. Conflict(s) of Interest

- Have you been an investigator in any research study involving the use of this drug?
__ Yes __ No
- Within the last two years, have you served as an advisor, received honoraria and/or research funding from the company manufacturing or promoting this product:
__ Yes __ No
- Do you have equity (outside of a mutual fund) in the manufacturer of this drug?
__ Yes __ No

If you answered yes to any of these questions, please provide further details of your relationship:

Requested by: _____, MD Date: _____

Printed name: _____

Department/Division _____

Signature of Division/ Unit Chief: _____

Name of Division Chief or Department Chairman: _____

Pharmacy Services Only:

Acquisition cost: \$ _____

Annual cost impact: \$ _____