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: __________________________________________________________________________
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 medication 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 ____________________________