REQUEST FOR FORMULARY ADDITION

Instructions: Date _____

A. **All** sections of this 2-page form must be completed by the requesting physician, including the financial disclosure section.
B. The completed original copy of this form and copies of articles should be returned to the Department of Pharmacy, Attn: P&T,Iredell Health Systems, 557 Brookdale Drive, Statesville, NC 28677. Tel: (704) 878-4599; Fax: (704) 878-7283
C. Requested drugs must be approved by the P&T Committee and Medical Executive Board before they are added to the formulary.
D. Consideration for formulary status will require physician attendance at P&T Committee meeting for presentation and addressing committee questions.

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1. Generic name: _____
2. Brand/trade name: _____
3. Dosage form(s): _____
4. Usual dose and route: _____
5. Pharmacologic class: _____
   List other formulary agents available in this class:

6. Indications:
   A. List the FDA-approved indication(s):

   B. List other indication(s) for which this agent may be considered at IHS:

7. List other formulary agents that are used for the same indication(s):

8. Evidence supporting superiority of the requested agent to current formulary agents:
   (Please attach 2 recently published articles with controlled studies supporting the value/advantage of the drug.)

   A. Situations in which the requested drug is superior to current formulary drug(s):
      Reference(s)/Data:

   B. Is it safer than other available therapies? Yes No
      Reference(s)/Data:

   C. Is it less expensive than other available therapies? Yes No
      Cost difference:

   D. Is it more effective in lowering overall health care costs? Yes No
      Reference(s)/Data

9. List current formulary agent(s) from item #7 that may be deleted from the formulary:

10. Should use of this agent be restricted:
A. Based on criteria? Yes No
If yes, list the suggested criteria:

B. To specific providers/specialties? Yes No
If yes, list the providers/specialties:

11. List any special precautions or side effects that might require specific monitoring:

List any special contraindications and interactions (drug-drug, drug-food, drug-lab):

12. Indicate the number of patients you anticipate would be treated annually with this agent: _____

DISCLOSURE

Please disclose any association that you have had with the manufacturer of this agent within the last 3 years.

Have you served as a member of an advisory board or speakers' bureau for the manufacturer? Yes No

Have you served as a consultant for the manufacturer? Yes No

Do you own stock in the manufacturer in excess of $10,000? Yes No

Have you had research funded by the manufacturer? Yes No

Have you received funding for travel or lodging from the manufacturer? Yes No

Have you received personal gifts in excess of $100 from the manufacturer? Yes No

Is there any other activity in which you are or have been engaged that might be regarded as constituting a conflict of interest for the purposes of the formulary request? Yes No
If yes, explain:

NOTE: This form will only be honored if it is completed by the requesting physician.

My signature below attests to the fact that I personally completed this form:

_____ _____
Printed Name of Physician Signature of Physician

_____ _____
Physician Phone Number Date Submitted

FOR USE BY PHARMACY AND THERAPEUTICS COMMITTEE

_____ _____
Date Received Date of meeting

P&T Committee Action: Approved Denied Tabled