Our Lady of the Lake Regional Medical Center
Formulary Addition Request Form

Instructions & Information

1) **Fill out all items as incomplete/illegible forms will be returned**
2) **Complete forms should be emailed to the Director of Pharmacy or faxed to (225) 765-9906.**
3) **Once the application is received, it will be placed on the P&T Committee Agenda. A drug review & class review (if indicated) will be conducted looking at safety, effectiveness, and cost. You will be notified of the committee's decision once the final decision is made by the Medical Executive Committee.**

Drug Requested

Generic Name:		**Brand Name:**	
Manufacturer:		Dosage Form(s) & Strength(s):	
Usual Dose, Route, Frequency & Duration of Therapy:			
Clinical Indication(s):			
1) Are there comparable drugs on the formulary?		☐ YES	☐ NO
2) List formulary medications:			
3) What significant advantages does the requested drug have over other available agents?			
4) What makes the requested drug superior to the formulary medication(s)?			
5) Please cite supporting references from medical literature for the requested drug:			
6) What drug(s) listed above could be deleted from the formulary?			
7) Have you have now or in the past received research support, have/had a consulting agreement, or are a member of an advisory board/speaker's bureau for the manufacturer of the requested drug?		☐ YES	☐ NO
Signature of Prescriber:		**Phone Number:**	
Printed Name:			

*******PHARMACY & THERPUETICS COMMITTEE USE ONLY*******

Pharmacy & Therapeutics Chair (Signature):			
Request:	☐ APPROVED	☐ APPROVED (with RESTRICTION)	☐ DENIED
Comments:			