Smart Medicine
STONY BROOK
UNIVERSITY HOSPITAL
Expert Care

Formulary Addition Request Form

This form is used to request additions to the Stony Brook Hospital Drug Formulary. Additions may only be requested by **attending physicians** or through needs identified by the Pharmacy Department.

I. Instructions

1. All portions of this form must be completed or it will be returned.
2. Submit completed forms, along with supporting documentation to the Director of Pharmacy Services at **mailbox 7007**
3. Forms must be submitted at least four weeks prior to a Pharmacy and Therapeutics Committee meeting (third Wednesday of the month) in order to be placed on the agenda of the next meeting and allow appropriate time for review.
4. The requestor(s) or physician designee should be available to appear before the Pharmacy and Therapeutics Committee when the drug is presented for approval.

Form received in Pharmacy by:_____ **Date:**_____

II. Drug Information *(Click on gray area and begin typing. Gray shading will not appear on printed document)*

- Generic Name: _____ Trade name(s):_____
- Manufacturer(s): _____
- Indication(s): _____

  Mechanism of action: _____
- Usual dosage, frequency, and duration of therapy: _____

  Anticipated **monthly** frequency of use:

  Number of patients: _____ Inpatients: ☐ Outpatients: ☐ *(to put an x in box, click on box icon)*

  Expected cost per patient admission: _____

  Comparable drug(s) on Formulary: _____

  Situations in which this drug is more effective/superior to medications on Formulary.

  _____

  Which drug(s) could be deleted from the formulary?

  _____

  Special risks, cautions and restrictions in use:

  _____

  Special considerations related to patient safety (“look alike, sound alike”):

  _____

  Pertinent literature references (attached):

  _____
- Suggested criteria for use. *Please attach additional sheets if necessary*.

  A. Inclusion Criteria: _____

  Monitoring parameters (*Including adverse drug reactions/interactions that may occur and preventative and/or responsive management for each):* _____

Outcome measures (markers to determine drug efficacy): _____

III. Miscellaneous Information

- 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

If you answered "yes" to either of the above questions, please explain:

_____

Requested by: _____, MD Date: _____

Printed Name;_____ Department/Division _____

Chair/Chief approval (signature): _____

(printed name) _____

P&T Committee Recommendation

Recommendation to add**:** ☐Yes ☐No Date of Meeting:_____

Signature, P&T Committee Chair:_____, MD

_____