APPLICATION FORM FOR
ADDITION OF NEW DRUG TO THE FORMULARY

Please legibly complete and return this form to the Pharmacy Department at Regional Office. The Pharmacy and Therapeutics Committee will review drug requests as scheduling of the Committee's meeting agenda permits, and the Committee may elect to withhold review of newly marketed drugs pending availability of post-marketing safety data. **Medical literature references which document advantages of the new drug must be submitted with the application. Application forms submitted without supportive scientific data (eg. clinical studies, case reports, consensus statements) will not be reviewed by the Committee until such data is presented by the requestor.**

1. Drug Generic Name: ______________________________ 2. Trade Name: ________________________________

3. Dosage Form(s)/Strength(s): _________________________ 4. Manufacturer: _______________________________

5. Is a specific brand necessary? No ____ Yes ____ If yes, identify. _________________________________

6. Therapeutic Use: ____
____
____

7. Reasons why drug is superior or equivalent to those presently on Formulary. List advantages and disadvantages as compared to existing formulary drugs. Include supportive data. ____
____
____

8. Which drug(s) can this addition replace on Formulary? What percentage of patients taking the formulary drug now in use will require the new drug, ie. estimated % of patients who will switch to new drug? _________________
____

9. List any drugs which can be deleted as a result of adding this drug. ____

10. Any restrictions? If yes, list specialty service and reason for restriction. ___________________________________
____

11. The policy of the Committee requires that the requesting physician submit criteria for use of this drug to the Committee. Please list criteria on the reverse side of this form.

12. Requested by: ____ Location: ________________________
Telephone ext. __________________________________ Date: ____________________________

Pharmacy and Therapeutics Committee Action: ____
____

Date: ________________ Committee Chairman: ____

This form is available at all Kaiser Permanente pharmacies.

drugadd.frm

DRUG MONITORING CRITERIA

(Please list one or two items under each heading.)

A. INDICATIONS (Note if FDA-approved):

____

____

____

____

B. CONTRAINDICATIONS:

____

____

____

____

C. MONITORING REQUIREMENTS:

1. **Labs:** __________________________________

   ____

2. **Radiology:** __________________________________

   ____

3. **Other (eg. dietary, follow-up office visits, etc.)** ____________________

   ____

D. EXPECTED OUTCOME:

____

____

____

____

This form is available at all Kaiser Permanente pharmacies.