



## 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.

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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?

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

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

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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 next page of this form.

12. Requested by:

Location: \_\_\_\_\_

Telephone: \_\_\_\_\_

Date: \_\_\_\_\_

Pharmacy and Therapeutics Committee Action: \_\_\_\_\_

Date: \_\_\_\_\_

Committee Chairman: \_\_\_\_\_

***This form is available at all Kaiser Permanente pharmacies.***

# DRUG MONITORING CRITERIA

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

## A. INDICATIONS (Note if FDA-approved):

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## B. CONTRAINDICATIONS:

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## C. MONITORING REQUIREMENTS:

### 1. Labs:

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### 2. Radiology:

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

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## D. EXPECTED OUTCOME:

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The application form must be legibly completed and mailed to Kaiser Permanente, Pharmacy Administration, Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, Georgia 30305-1736.