THE UNIVERSITY HOSPITALS AND CLINICS THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
Jackson, Mississippi

Pharmacy and Therapeutics Committee

FORMULARY ADDITION REQUEST FORM

Instructions for Use

1) Attending physicians on staff at UMC and Director of Pharmacy may request additions to the medication formulary.

2) The information requested in this form must be completed and submitted to the Chair of the UMC Pharmacy and Therapeutics Committee (c/o Systems Clinical Manager, Department of Pharmacy Services)

3) The Committee must receive this completed form at least four weeks prior to the next scheduled meeting in order for the request to be on the agenda.

4) Requests for addition to formulary can be processed ONLY after all necessary information is complete and received by the Chair.

5) Use additional paper if necessary to adequately complete the information requested.

6) Providing a product package insert does NOT meet the requirements of this form.

7) Requests will only be accepted for medications that have been on the U.S. market for at least six months unless committee deems necessary to grant waiver.

8) The last page of this packet REQUIRES the signature of the requesting Division/Department’s Chair.

9) Forward all necessary items to the Chair of the Pharmacy and Therapeutics Committee (c/o Systems Clinical Manager, Department of Pharmacy Services).

10) Monograph presentation and voting process:
   a) Medication monograph presented by Department of Pharmacy.
   b) Further pertinent information provided by the requestor, if applicable.
   c) Time for questions and discussion between P&T Committee members, Department of Pharmacy and requestor.
   d) After all questions have been addressed, the requestor will be asked to excuse

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themselves prior to motions being made.

11) In the event that the Formulary Committee recommends that the requested medication not be added to the formulary or a medication be removed from the formulary, there will be a 6 month period before the Formulary Committee will reconsider a request for the same medication. A review will only occur if a request is made. This time period should be used by the requestor to collect more evidence to present to the Committee. An exception to this 6 month waiting period would be in the event that literature is published which supports a major breakthrough (efficacy, safety, or substantial cost savings) concerning the medication in question. If the requesting provider feels that more rapid approval of the medication is critical to patient care, they may bring their request directly to the Chair of the P&T Committee.

Return to:

Chair, Pharmacy and Therapeutics Committee
C/O Systems Clinical Manager
Department of Pharmacy Services
FORMULARY ADDITION REQUEST FORM

Medication name (brand and generic):

Manufacturer:

Dosage form(s) and strength(s) requested:

Intended indications (if indication is not FDA-approved, literature citations supporting clinical efficacy and safety MUST be provided):

List the current formulary options for the indications listed above:

Describe the therapeutic need for the requested medication (why is routine availability of this medication necessary?)

Describe the requested medication’s role in therapy compared to current formulary options (description must include discussion of results of randomized clinical trials):

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Will the anticipated use of the requested medication be consistent with current published practice guidelines, and/or with FDA-approved indications, and/or standard of care medical practice? (provide citations)

Describe the data supporting the requested medication’s superiority over current formulary options (in terms of efficacy and safety):

List any medications currently on formulary that the requested medication could replace, and specify why (if none, specify why not):

Describe how efficacy of the requested medication will be monitored:

Describe how safety and tolerance of the requested medication will be monitored:
Estimate the anticipated usage of requested medication (how many patients per month):

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<tr>
<td>Inpatient</td>
<td>______ patients per month</td>
</tr>
<tr>
<td>Outpatient</td>
<td>______ patients per month</td>
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<tr>
<td>Average duration of therapy</td>
<td>______ days</td>
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<td>Other:</td>
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List the costs of each dose/formulation of the requested medication:

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Estimate impact on other departments (e.g. laboratory, radiology):

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Should prescribing of the requested medication be restricted to a particular medical service, and/or to a specific indication?

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Disclose any potential conflicts of interest you have with making this request:

List any potential conflict of interest that you may have with regard to the formulary request and the respective pharmaceutical manufacturer. This disclosure statement must include any financial arrangements or affiliations with the pharmaceutical company or organization including:

- Substantial ($1000 or more) personal financial holdings, such as directly purchased stocks or security holdings
- Consultant or advisory board appointments
- Formal or informal appointments to a company sponsored Editorial Board or Speaker’s Bureau (defined as more than one lecture in the past twelve months that has been sponsored by the same company)
- Significant research funding arrangements (defined as the receipt of more than $1000 in research funds in the past twelve months)

If potential conflict of interests exists, please detail below:

I, the below signed, hereby certify that I have personally completed this form in its entirety.

Name of requesting physician: ____________________________

(Please type or print)

Signature of requesting physician: ____________________________

Division and/or Department: ____________________________

Date: ____________________________

Name of Division Head / or Department Chair: ____________________________

Signature of Division Head / or Department Chair: ____________________________

(REQUIRED)

Date: ____________________________

Revised 3/14