Bon Secours Richmond Health System
Formulary Drug Addition Form

1. Drug
   a. Generic Name:
   ____
   b. Trade Name:
   ____

2. Dosage form(s):
   ____
   ____

3. For which condition(s) are you primarily planning to use this product? (If left blank, the most common FDA approved use will be assumed for the purposes of preparing the drug review.)
   ____
   ____

4. Attach references to this form to support the reason for your request. Inclusion of this literature will greatly assist us in directing a thorough drug review.

5. Will this drug replace a formulary drug? If so, which drug(s)?____________________________
   ____

6. Include the advantages of the requested drug over one or more of the currently accepted formulary drugs.
   ____

7. Compared to formulary items this medicine is (circle all that apply):
   Safer
   More Effective
   More Cost Effective

8. Anticipated frequency of use (number of patients, duration of therapy, etc.)______________________

9. Please return completed Formulary Drug Request Form to the Department of Pharmacy.

10. Once the application is received, it will be placed on the System Pharmacy and Therapeutics Committee meeting agenda for the next scheduled session. A drug review will be performed of the requested agent. In this review, the class of agents to which the requested agent belongs will be compared for efficacy.

11. The Pharmacy & Therapeutics Committee recommendation, once made, is submitted to the Medical Executive Committee for approval.

______________________________	______________________________
(Requested By)	(Form Completed By)
______________________________	______________________________
(Service)	(Date)

Potential conflict of interest disclosure form must be completed and submitted with the Formulary Addition Form

Bon Secours Richmond Health System
Potential Conflict of Interest Disclosure Form
For Physicians Requesting an Agent for Formulary Addition

Please answer the following questions with respect to the drug requested for Formulary Addition:

1. Do you now or have you in the past received research support from the manufacturer of this agent?_____________

2. Do you have a consulting agreement with the manufacturer of this agent? ______________

3. Are you a member of an advisory board or consulting panel for the manufacturer of this agent?______

4. Do you, your spouse, or your immediate dependents have any financial interests in the manufacturer of this agent?_________

Physician Completing Form:____

For Pharmacy Use Only

Date received:__________________ Anticipated P&T Committee review date:______________________________