NEW DRUG REQUEST

THRU: *(Specify Department)* Chief	**TO:** Chief Pharmacy Service	**FROM:** *(Physician's Name and Location)*		
1. GENERIC NAME	2. TRADE NAME(S)	3. MANUFACTURER	4. DOSAGE FORM(S)	5. MONTHLY USAGE *(Estimated)*

6. RECOMMENDATIONS
- ☐ ONE TIME PURCHASE
- ☐ GENERAL USE
- ☐ CLINICAL TRIAL
- ☐ RESTRICTIONS *(Specify)*

7. THERAPEUTIC INDICATIONS

8. ADVANTAGES OF REQUESTED DRUG

9. DELETED DRUGS *(If new drug is approved)*

DATE	TYPED NAME OF REQUESTING PHYSICIAN	SIGNATURE

FOR COMPLETION BY CHIEF OF DEPARTMENT

10. RECOMMENDATIONS
- ☐ ONE TIME PURCHASE
- ☐ GENERAL USE
- ☐ RESTRICTIONS *(Specify in Item 11)*
- ☐ CLINICAL TRIAL
- ☐ DISAPPROVED

11. REMARKS

DATE	TYPED NAME AND TITLE	SIGNATURE

FOR COMPLETION BY CHIEF, PHARMACY SERVICE

12. REMARKS/RECOMMENDATIONS

13. COST COMPARISON

FOR COMPLETION BY THERAPEUTIC AGENTS BOARD

14. RECOMMENDATIONS
- ☐ ONE TIME PURCHASE ONLY
- ☐ GENERAL USE
- ☐ CLINICAL TRIAL
- ☐ STANDARDIZATION
- ☐ RESTRICTIONS *(Specify in Item 15)*
- ☐ DISAPPROVED *(Specify in Item 15)*

15. REMARKS

DATE	TYPED NAME AND TITLE	SIGNATURE