

NEW DRUG REQUEST

THRU: <i>(Specify Department)</i> Chief Pediatrics	TO: Chief Pharmacy Service	FROM: <i>(Physician's Name and Location)</i> B. Paul Choate, M.D. Pediatric Clinic
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1. GENERIC NAME	2. TRADE NAME(S)	3. MANUFACTURER	4. DOSAGE FORM(S)	5. MONTHLY USAGE <i>(Estimated)</i>
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6. RECOMMENDATIONS <input type="checkbox"/> ONE TIME PURCHASE <input type="checkbox"/> GENERAL USE <input type="checkbox"/> RESTRICTIONS <i>(Specify)</i> <input type="checkbox"/> CLINICAL TRIAL	7. THERAPEUTIC INDICATIONS
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8. ADVANTAGES OF REQUESTED DRUG	9. DELETED DRUGS <i>(If new drug is approved)</i>
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DATE	TYPED NAME OF REQUESTING PHYSICIAN B. Paul Choate, M.D., Pediatric Clinic	SIGNATURE
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FOR COMPLETION BY CHIEF OF DEPARTMENT

10. RECOMMENDATIONS <input type="checkbox"/> ONE TIME PURCHASE <input type="checkbox"/> RESTRICTIONS <i>(Specify in Item 11)</i> <input type="checkbox"/> CLINICAL TRIAL <input type="checkbox"/> GENERAL USE <input type="checkbox"/> DISAPPROVED	11. REMARKS
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DATE	TYPED NAME AND TITLE Joseph M. Dai, COL, MC, Chief, Pediatrics	SIGNATURE
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FOR COMPLETION BY CHIEF, PHARMACY SERVICE

12. REMARKS/RECOMMENDATIONS

13. COST COMPARISON

FOR COMPLETION BY THERAPEUTIC AGENTS BOARD

14. RECOMMENDATIONS <input type="checkbox"/> ONE TIME PURCHASE ONLY <input type="checkbox"/> STANDARDIZATION <input type="checkbox"/> GENERAL USE <input type="checkbox"/> RESTRICTIONS <i>(Specify in Item 15)</i> <input type="checkbox"/> CLINICAL TRIAL <input type="checkbox"/> DISAPPROVED <i>(Specify in Item 15)</i>
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15. REMARKS

DATE	TYPED NAME AND TITLE	SIGNATURE
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