Ventura County Health Care Agency
Ventura County Medical Center
Santa Paula Hospital
Department of Pharmacy Services

Formulary Addition/Deletion/Restriction/Sample Distribution Request Form

Request for: ☐ Addition ☐ Deletion ☐ Restriction ☐ Sample Distribution (Clinics Only)

1. Generic Name: ____
2. Trade Name(s):____
3. Manufacturer Name:____
4. Dosage Forms Desired (e.g., capsules, tablets, etc.):__________________________
5. Dosage Strengths Desired: ____
6. Intended Therapeutic Applications: ______________________________________

____

7. Similar Products Currently on the Formulary: ________________________________
8. Reason(s) why this drug should be added/deleted/restricted on the Hospital Formulary:

____

9. Should other drug(s) listed in "7" above be replaced by this newly recommended medication? _____ YES _____ NO If Yes, which ones(s)? _________________________

____

10. References: ____

Name of Requestor:_______________________ Email:____________________________

Signature of Requestor: ____________________ Date: ____________________________

Please forward this completed form, with any additional information you wish to include, to the Department of Pharmacy Services for Pharmacy and Therapeutics Committee review.

FOR PHARMACY USE ONLY

Action taken by the Pharmacy and Therapeutics Committee: _________________________

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Chairman, Pharmacy and Therapeutics Committee ___________________ Date: _________

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