PHARMACEUTICAL & SUPPLY CHANGE REQUEST

Requested by: _____ Site & Dept: _____ Date: _____

Contact Number & Extension: _____

Item Name: _____ Covered By: ☐Medi-Cal ☐Insurance ☐CMSP ☐FPACT ☐Other _____

(i.e. capsule, tablet, injectable, single use syringe, etc)

Strength: _____ Qty: _____ Form: _____

Manufacturer: _____ NDC Code: _____

Change Requested: ☐Add Item ☐Remove Item ☐Other _____

☐Change Vendor ☐Change Code ☐Change Price

Justification for Request:

Send this form to Gail Kuwahara, Clinical Operations Assistant. Gail will obtain any missing information and send it on to the Pharmacy Committee for review.

Purchasing - *Price & Ordering Information*

Quantity per Unit: _____ Price per Unit: $_____

Vendor: ☐ Allscripts ☐ Cardinal ☐ Patient PAK-340b ☐ McKesson ☐ DSI

☐ Other: _____

ODCHC has an account with this Vendor? ☐ Yes ☐ No

Authorization: ☐ Approved ☐ Denied (Return to Requestor)

Signature: _____ Date: _____
Medical Director

Signature: _____ Date: _____
Operations Director

Coding Assignments: GL ☐☐☐ - 0 - Site ◆◆ - Dept ☐☐☐ - Grant ☐☐☐

Pricing: _____
8000 Code #: _____

Copy of approved form: ☐ Purchasing ☐ Meds Room ☐ Billing Mgr ☐ Systems Analyst ☐ Other _____