Attachment A from Medication Samples

Request to Receive Sample Medication (or covered Medical Supply samples) at Denver Health

Please complete this form in its entirety.

Medication (or covered medical supply sample) Information:

<table>
<thead>
<tr>
<th>Generic Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand Name</td>
<td></td>
</tr>
<tr>
<td>Strength</td>
<td></td>
</tr>
<tr>
<td>Dosage Form</td>
<td></td>
</tr>
<tr>
<td>Manufacturer</td>
<td></td>
</tr>
<tr>
<td>Planned location for sample use</td>
<td></td>
</tr>
</tbody>
</table>

Pharmaceutical company supplied: Y/N
Grant supplied medication: Y/N

Specific reason the sample medication is being requested at Denver Health:

___________________________________________________________________________________
___________________________________________________________________________________

What is the value of using these samples to DH?
___________________________________________________________________________________
___________________________________________________________________________________

Plan for acquisition: ________________________________________________________________

Plan for storage: ________________________________________________________________

Plan for documentation and tracking of samples:
__________________________________________________________________________________

Plan for documentation of dispensing: ________________________________________________
__________________________________________________________________________________

Version Date: 2/2021
Plan for monitoring for expiration or if medication is recalled: ______________________________

Anticipated volume of samples to be dispensed per month: ______________________________

Anticipated duration of need for samples and total number of samples to be dispensed:
________________________________________

Director of Service for care provided in the area: ______________________________

**Director of Service or designee will be responsible for implementing above plan including storing and dispensing of the sample medication.**

Signature of DOS: ______________________________

Date Requested: ______________________________

After completion, submit this form to P&T email: pharmacy-therapeutics@dhha.org