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:

Generic Name	
Brand Name	
Strength	
Dosage Form	
Manufacturer	
Planned location for sample use	

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: _____

_____

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