University Health System

REQUEST FOR PRODUCT EVALUATION

Please place a check in the appropriate box

To: Patient Care Services Product Evaluation Committee ☐

Physician Product Evaluation Committee ☐

From: Telephone #

E-Mail Address: Date:

Subject: Request for Product Evaluation Committee Action

Request the following product(s) be approved for use within the University Health System.

Description of Item:

Manufacturer:

Does the physician(s) who will be utilizing this product have hospital privileges in this area? If yes, please include a copy of the Delineation of Privileges.

Is this a budgeted item or on the Capital Prioritization List ☐ Yes ☐ No
If you answered "Yes" please proceed and provide validation that the item is included as noted above. If you answered "No" please contact the Director of the Department where this item(s) will be primarily used.

Describe specific use of requested product and why it is needed:

Identify the patient care areas and UHS facilities that will utilize the requested product (Inpatient, Outpatient, Outpatient Surgery):

Will this replace other products or services currently utilized in the University Health System?

If yes, what are they, where are they used, and how much do they cost?

What is the expected case load or amount of product expected to be needed during the initial year?

Cost of proposed item(s)?

What is the total annual expenditure for these items?

Is this expense included in the current Year's annual operating Budget?
YES: **NO:** If no, how will the purchase of this item be funded?

Explain

How will this product change the current treatment/procedure?

Identify benefits from using this product (i.e. reduction of LOS or re-admissions, improve patient outcome, cost benefit, no revenue generation, etc.)

Are there any Risks Associated with this product?

If yes, please explain:

What DRG, Principal Diagnosis Code, and/or ICD-9 Procedure Code does the treatment/procedure for which this product is used fall under? What is the current reimbursement for this treatment/procedure by payer?

Do you recommend a restriction on the use of the supply?

If yes, what restriction?

Is this product FDA Approved? **YES:** **NO:**

Will this product be used for Humanitarian Purposes? **YES:** **NO:**

Are there any other Healthcare Facilities in the Community utilizing this product?

YES:	**NO:**

If yes, which other Healthcare Facilities

Please List:
(1)
(2)
(3)

Is this product part of a research protocol?

YES:	**NO:**

If yes which Research Protocol?

Name:

Principal Investigator**:**

Department**:**

Conflict of Interest Statements:

- **I do not have a conflict of interest**. (Initials)

- I have the following financial interest/arrangements/affiliation with one or more organizations that could be perceived as a real or apparent conflict of interest in the context of this request.

Details**:**

Please submit online and Fax this page attention: Francine Crockett 358-8509 for proof of signature.

Signature (person submitting request) Date

Signature (Department Director) Date

Approve/Disapprove

Department Chairman Date