Henry Mayo Newhall Hospital

Reference #:_____

New Product Request Form

Instructions: Use this form to request the purchase of new clinical product. All required information must be completed for VAC sub-committee consideration. For questions or assistance in preparing this form, please send an email to: vac_committee@henrymayo.com. The respective service line leader will be in contact with you to respond to your questions. Please submit completed forms with necessary attachments to: vac_committee@henrymayo.com.

Section I: Requestor Information

Physician/Clinician Requestor:	Title:	Service Line/Specialty:
Department:	**Requestor's Telephone #:**	**Requestor's Email:**
Request Completed By:	**Telephone #:**	**Date Submitted:**

Section II: Request Type

If approved, this product will:	☐ Request to trial product	☐ Use based on clinical necessity, non-stock	☐ Add product to inventory, regular use
	Product/Equipment Name	**Catalog/SKU #(s)**	**Meditech #(s)**
☐ Duplicate the following existing product(s) or ☐ Replace the following product(s): (Please complete and attach spreadsheet if needed)			

Section III: New Product Information

Product Type:	☐ Supply	☐ Equipment	☐ Both
Product/Equipment Name:		**Manufacturer:**	
Catalog/SKU #(s)		**Price of Product(s)/Equipment:** (please note: all capital request must be approved by the Capital Committee)	
Anticipated Volume:		**Is the current product under an existing Contract?** ☐ Yes ☐ No **If yes, when does the contract expire?**	

Brief Description of Intended use:/Procedure or Diagnosis:

What is the benefit of the use of the requested product/equipment in terms of impacting Cost, Quality and Outcomes (CQO)?

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Reason for the Request: (Please check all that apply)

☐ Physician Request	☐ Cost reduction	☐ Enhances patient satisfaction
☐ Product standardization	☐ WCPC Cost Savings Initiative	☐ Environmental
☐ Improves clinical outcomes	☐ Vizient Achieve Committed Program	☐ Diversity Supplier
☐ Safety	☐ Latex Free	☐ Regulatory

Name of Vendor Representative: _____ **Telephone #:** _____

Vendor's email: _____ **Is this product FDA approved?** ☐ Yes ☐ No

If this is a replacement, is the current product under contract? ☐ Yes ☐ No
If yes, when is the contract expiration date?

Has the new product been awarded a Vizient GPO/WCPC contract? ☐ Yes ☐ No

Is this product intended for off label use? ☐ Yes ☐ No
Is there an approved alternative device? ☐ Yes ☐ No
Is there medical literature supporting the intended use? ☐ Yes ☐ No (if yes please attach documentation)
Is there a protocol or procedure written for the use? ☐ Yes ☐ No
Is a trial of this product requested? ☐ Yes ☐ No **If yes, how long?** _____
Will product be provided at no charge? ☐ Yes ☐ No **If yes, how many?** _____
If there is a charge for the trail, please provide the cost per unit _____
If there is a product-related incident, what will be the manufacture, user and hospital's liability?

Conflict of Interest Statement

Requesting Physician and/or Departments must complete this conflict of interest statement. This information will be shared with the VAC members and will be taken into consideration when discussing your request. A potential conflict of interest issue does not disqualify someone from request the product.

Do you or an immediate family member own stock in the company (excluding mutual funds)? ☐ Yes ☐ No

Do you serve on the board of directors of the company? ☐ Yes ☐ No
Have you been employed as a consultant for the company? ☐ Yes ☐ No
Have you received any financial support from the company as listed below? ☐ Yes ☐ No
Funding for research? ☐ Yes ☐ No
Support for presenting continuing education or other professional education supported by the company? ☐ Yes ☐ No
Received an education grant ☐ Yes ☐ No
Received travel support ☐ Yes ☐ No
Other (please elaborate) ☐ Yes ☐ No

Physician/Requestor's initials: _____

Please attach the following documents:

1. **FDA 510K approval**
2. **Product detail and reference sources for clinical evidence of safety and efficacy**
3. **Literature, white papers to support the request from unbiased sources**
4. **Vendor VAC packet**

Section IV: Requestor and Department Signatures to Review NPR

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Requesting Physician/Clinician Name (Printed)	**Requesting Physician/Clinician Signature**	**Date**
Service Line Medical /Clinical Director's Name (Printed)	**Service Line Medical/Clinical Director's Signature**	**Date**
VAC Chair Name (Printed)	**VAC Chair Signature**	**Date**
Supply Chain Director Name (Printed)	**Supply Chain Director Signature**	**Date**

Submit completed forms to: vac_committee@henrymayo.com

SUBMIT