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| G-12 NEW DRUG DATA **IRB # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  *Upon approval from P & T Subcommittee, and after the patient has consented to participate, the investigator must assure that this completed form is filed/scanned in to the patient’s medical record.*  ⚫File most recent sheet of this number ON BOTTOM⚫ | | | | DATE  HOSP. #  NAME  BIRTH DATE  ADDRESS  IF NOT IMPRINTED, PRINT DATE, HOSP. #, NAME AND LOCATION | |
| **Generic Name:** | | | **Trade Name:** | | |
| **Other Names: (e.g., Chemical Name, Investigational Name/Number, IND# if applicable)** | | | | | |
| **Drug Class:** | | | **Use:** | | |
| **Site and Mechanism of Action:** | | | | | |
| **Onset of Action:** | | | **Duration of Action:** | | |
| **Metabolism & Excretion:** | | | | | |
| **Dosage:** | | | **Duration of Study Drug Treatment:** | | |
| **Interacting Drugs:** | | | | | |
| **Adverse Effects:** | | | | | |
| **Toxicity Management:** | | | | | |
| **Investigator Names** | | **Preferred Contact Phone #** | | | **Hospital extension/pager #** |
| **1.** | |  | | |  |
| **2.** | |  | | |  |
| **3.** | |  | | |  |
| **References:** | | | | | |
| **Double Blind Test? ❑Yes ❑No** |  | | | | |

Revised 8-22-18 UNIVERSITY OF IOWA HOSPITALS AND CLINICS

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