**PHARMACY IMPACT FORM / REQUEST FOR PHARMACY SERVICES**

All drugs or Natural Health Products (NHP) for inpatient clinical trials must be dispensed by Research Pharmacy in the Pharmacy Department. All outpatient clinical trials using an investigational product (drug/NHP) must be registered with Pharmacy, whether or not the trial is using pharmacy services. If pharmacy is dispensing and/or ordering the drug/NHP, all orders must be entered in Epic. If dispensing will be done by an appropriately qualified and licensed member of the study team, drug must be entered into Epic, therefore “study registration AND an ERx order build” request must be indicated on this form, so the research product will be built and orderable within Epic. This will ensure evidence of the physician order on the patient record. If however, patients will be provided a prescription which will be filled at an external pharmacy (i.e. Phase IV), research staff should select “registration of study only” and document the study medication under “patient self-reported medication” to ensure it is captured in the patient’s medical record.. Studies using Cancer Centre Pharmacy do not require registration. OHRI staff refer to [N2 SOP 010, OHRI Addendum](http://www.ohri.ca/extranet/clinical_research/documents/N2%20SOP%20010%20-Management%20of%20Investigational%20Product%20Addendum%20Revised%20June%202019%20FINAL.pdf) for further specific local instructions.

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| Request for Research Pharmacy Services: | **YES** (pharmacy manages the product, preferred scenario)  **If yes, will additional evening/weekend, on-call coverage be requested?**  **YES NO** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **NO, study registration AND ERx order build in Epic only** | | | | | | | | | | | **NO, study registration only (meds to be recorded in patient self-reported med section of Epic record)** | | | | | | | | | | | | | | | | | |
| Campus where trial will be conducted: ( **X** ) | | **CIVIC GENERAL**  **RIVERSIDE UOHI** | | | | | | | | | | | | | | | | | | **OTHER (Specify)**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | |
| Specify participant location: | | **Out-patient**  **# of out-patients:** | | | | | | | | | **In-patient**  **# of in-patients:** | | | | | | | | | | | | **Both** | | | | | | |
| PROTOCOL TITLE: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Protocol Number: | | | | | Acronym (if any): | | | | | | | | | | | | | | | | | | | | | | | | |
| CRRF Form ID: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Principal Investigator: | | | | Telephone # | | | | | Fax: | | | | | | | | | | | E-mail: | | | | | | | | | |
| Study Coordinator: | | | | Telephone # | | | | | Fax: | | | | | | | | | | | E-mail: | | | | | | | | | |
| Industry Sponsored  **OR**  Investigator-Initiated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SPONSOR: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Clinical Trial Monitor: | Telephone # | | | | | | | | Fax: | | | | | | | | | | | E-mail: | | | | | | | | | |
| Anticipated Start Date: | Length of Study: | | | | | | | | | | | | | Total # Patients: | | | | | | | | | | | | | | | |
| If drugs are to be administered within the UOHI/TOH, does the medication require: | 1. Special Preparation: 2. Return of Used Dosage Containers: 3. Special Storage (e.g. refrigeration): | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Provided Documents: | Protocol  version date: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | Investigator Brochure  version date: \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| TOH/OHRI Billing Information | Entity | | Campus | | | Cost Centre | | | | | | | | | | | | | | Account | | | | | | | | | |
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| *Pharmacy fees will be billed bi-annually (****April and October****). The Ottawa Hospital Finance Department will transfer funds from the above cost centre to the Pharmacy Research Cost Centre. A copy of the Pharmacy Invoice will be forwarded to the Investigator or designee for your records* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Investigator or Designee Signature: | | | | | | | | | | | | | | Date sent to pharmacy: | | | | | | | | | | | | | | | |
| Please Note: This Form must be completed, signed by pharmacy and submitted electronically in the Clinical Research Registration Form (CRRF) prior to study commencement.  For the **General and Riverside** return completed form to:  Pharmacy Department: Tel (613) 737-8970, Fax : (613) 739-6834 Email: [prxstudytechs@toh.on.ca](mailto:prxstudytechs@toh.on.ca)  For the **Civic and UOHI** return completed form to: Pharmacy Department (Room CS06-1) **Attention: Sherry Weir** Tel: (613) 798-5555 EXT 16772 Fax: (613) 761-4350 Email: [sweir@ottawahospital.on.ca](mailto:tgyapong@ottawahospital.on.ca) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**Sign off by Research Pharmacy:** ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_

Name Signature Date

For Pharmacy Office use:

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| Institutional Number/Study Code: | Institutional Approval Date: |