**Product Request Form**

**If you have any questions, please contact Toni Young, CQPVA Administrator, at (989) 583-4277.**

**REQUEST INFORMATION**

**Name:**

**Phone:**

**Email:**

**Request Type:** [ ]  **Conversion** [ ]  **Standardization** [ ]  **Utilization** [ ]  **New Product**

**Does requestor have any relationship with the supplier or supplier representatives?** [ ]  **Yes** [ ]  **No**

**If yes, explain:**

**Is this request made on the behalf of another requestor?** [ ]  **Yes** [ ]  **No**

**If yes, please state the name of the requestor:
Please list the physicians and/or departments that would use this product:**

**NEW PRODUCT**

**Product description:**

**Manufacturer name:**

**Manufacturer catalog number:**

**Does this product come in multiple sizes?** [ ]  **Yes** [ ]  **No**

**Is the product implanted?** [ ]  **Yes** [ ]  **No**

**Are there any other products that need to be used in conjunction with this specific product?** [ ]  **Yes** [ ]  **No**

**Unit of measure:**

**Cost per each:**

**Estimated annual usage:**

**Is capital equipment involved to use this product?** [ ]  **Yes** [ ]  **No**

**If yes, please explain:**

**CURRENT PRODUCT**

**Is this a replacement?** [ ]  **Yes** [ ]  **No**

**Current product description:**

**Current manufacturer name:**

**Current manufacturer number:**

**Unit of measure:**

**Cost per each:**

**Estimated annual usage:**

**Current Lawson number:**

**BILLING INFORMATION (This must be completed for any Surgical or Cardiovascular product.)**

**Is this an outpatient or inpatient procedure?** [ ]  **Yes** [ ]  **No**

**If available, please provide the ICD 10 Code:**

**If available, please provide the CPT code:**

**What is the diagnosis or diagnoses to use this product?**

**What is the procedure or procedures that this product could be used?**

**Where would the procedure be performed? (Please be specific: Cooper OR, Harrison OR, etc.)**

**CLINICAL INFORMATION**

**Describe the reason the current product is not acceptable:**

**What workflow processes will be resolved with this product?**

**Describe how the product/device will be used:**

**Describe how the product will impact patient care:**

**Is physician/staff training required for the use of this product?** [ ]  **Yes** [ ]  **No**

**Have you spoken with peers that may also use this product?** [ ]  **Yes** [ ]  **No**

**ADDITIONAL ITEMS**

**Is this product FDA approved?** [ ]  **Yes** [ ]  **No**

**Does the FDA have guidelines imposed for the product use?** [ ]  **Yes** [ ]  **No**

**If the product is not FDA approved, is there an expected timeframe for approval?**

**Is the intended use of the product FDA approved or off label?** [ ]  **FDA approved** [ ]  **Off label**