DRUG SHORTAGE WAIVER REQUEST FORM
(One medication waiver request per form)

Date: ______________________________________

Provider Name: ____

Requested By:____
Name, Title (please print)

Name of Medication: ____

Concentration (mg/ml): ____

Attempt to locate from other sources: ___ Yes ___ No

Substitution Request (Alternative packing, concentration, or amount): ___ Yes ___ No ___ N/A

Requested Substitution: ____

Concentration (mg/ml) ____

Training provided for substitution: ___ Yes ___ No ___ N/A

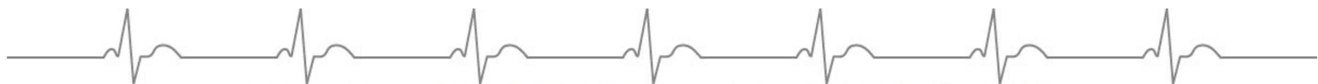
Waiver requested for: ___ 30 days ___ 60 days ___ 90 days

You are advised that your agency and ordering medical director are solely responsible for full compliance with all local, state, and federal regulations governing purchase, distribution, storage and administration of all medications including controlled substances. Any loss or diversion of such substances must be immediately reported to REMSA and appropriate state or federal agencies. The provider agency must provide adequate education to staff to prevent potential medication errors, this education must be in accordance with REMSA Policies and Procedures, and include standards set in REMSA 7310. The completion of this education must be recorded on an approved REMSA Education Roster.

REMSA USE ONLY

Date received: ______________________ Waiver Requirements Verified: ___ Y ___ N
Waiver Granted: ___ Y ___ N Date Granted: ________________ Date Expires: _________________
Approved By:____

Provider must notify REMSA immediately if the shortage or substitution adversely impacts the care of any patient. Send completed form to shkissel@rivco.org.



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