ALTERNATIVE MEDICATION / EXPIRED MEDICATION WAIVER FORM v632021

(One request per form)

Alternative Medication Request

Complete this section of the form when:

- A recognized national supply limitation prohibits your ability to stock a REMSA authorized medication, as outlined in Policy #3303 (*Drug and Equipment List*) and Policy #4102 (*REMSA Calculation Chart*), in either the preferred or alternative concentration(s) **AND**
- You do not have enough reserve cache to appropriately stock your response vehicles before your next medication delivery arrives.
- Your existing supply would be exhausted, and you would be unable to maintain REMSA prescribed par levels, as outlined in Policy #3303 (*Drug and Equipment List*)

Name of the medication in limited supply: _____

Concentration of the medication in limited supply (mg / ml): _____

Have you attempted to procure this medication from multiple suppliers? ☐ No ☐ Yes

If yes, provide supplier names: _____

Name of the medication to be used as an alternative: _____

Concentration of the medication to be used as an alternative (mg / ml): _____

Is extra training required prior to deployment? ☐ No ☐ Yes

If yes, include training documents with this form

How long do you expect to need this waiver? ☐ 30 days ☐ 60 days ☐ 90 days

Expired Medication Waiver Request

Complete this section of the form when:

- A recognized national supply limitation prohibits your ability to stock a REMSA authorized medication, as outlined in Policy #3303 (*Drug and Equipment List*) and Policy #4102 (*REMSA Calculation Chart*), in either the preferred or alternative concentration(s) **AND**
- You have enough reserve cache to appropriately stock your response vehicles before your next medication delivery arrives **BUT**
- Your existing supply would be expired while deployed

Name of the medication that will be expiring: _____

Concentration of the medication that will be expiring (mg / ml): _____

When does this medication expire (month / day, if present / year)? _____

Have you attempted to procure this medication from multiple suppliers? ☐ No ☐ Yes

If yes, provide supplier names: _____

When did you place your order? _____

How long do you expect to need this waiver? ☐ 30 days ☐ 60 days ☐ 90 days

Mailing Address: 450 E. Alessandro Blvd • ATTN: REMSA • Riverside, CA 92508
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You are hereby advised that your agency, and your agency's medical advisor, are solely responsible for full compliance with all local, state, and federal regulations governing the 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 all appropriate state or federal agencies.

If an alternative medication will be used, the provider agency must provide adequate education to all staff to prevent potential medication errors. This education must be in accordance with all REMSA policies and procedures and completion of this education must be recorded on an approved REMSA Continuing Education Roster.

Today's date: _____ Agency name: _____

Your name: _____ Your title: _____

REMSA must be notified immediately if the shortage or substitution adversely impacts the care of any patient.

Send completed forms to drascon@rivco.org

REMSA USE ONLY

Date Received: _____ Waiver requirements verified: ☐ Yes ☐ No

Waiver granted? ☐ Yes ☐ No Date granted: _____ Date expires: _____

Approved by: _____

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