

Dispense as Written (DAW) Drug Policy

Effective Date: 01/28/2020

Date Developed: 12/18/2019 by Howard
Taekman, MD

Date Approved by P&T Committee: 2/18/20

Ventura County Health Care Plan will review and approve requests for brand name medication where the prescribing physician has requested “Dispense as Written” or “DAW” and consider its use as medically necessary when the following criteria have been met.

Pre-Authorization Criteria:

Approve if the Brand product being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction **AND** has a completed FDA MedWatch form and submitted to FDA.

The completed FDA MedWatch form must be included with this request (see attachment 1). A copy of the FDA MedWatch form may be obtained online at:

<https://www.accessdata.fda.gov/scripts/medwatch/index.cfm>

Attachment: Med Watch Consumer Voluntary Reporting (Form FDA 3500B)

Revision History:

Date Developed: 12/18/19 by H. Taekman, MD and R. Sterling, MD

Date Reviewed/No Updates: 2/18/20 by H. Taekman, MD; R. Sterling, MD

Date Approved by P&T Committee: 2/18/20

Revision Date	Content Revised (Yes/No)	Contributors	Review/Revision Notes
2/18/20	No	Howard Taekman, MD; Robert Sterling, MD	New

Attachment 1: Med Watch Consumer Voluntary Reporting (Form FDA 3500B)

FDA	DEPARTMENT OF HEALTH AND HUMAN SERVICES Food and Drug Administration	Form Approved: OMB No. 0910-0291 Expiration Date: 11/30/2021 (See PRA Statement below)
	MEDWATCH Consumer Voluntary Reporting (FORM FDA 3500B)	

When do I use this form?

- You were hurt or had a bad side effect (including new or worsening symptoms) after taking a drug or using a medical device or product.
- You used a drug, product, or medical device incorrectly which could have or led to unsafe use.
- You noticed a problem with the quality of the drug, product or medical device.
- You had problems with how a drug worked after switching from one maker to another maker.

Don't use this form to report:

- Vaccines – report problems to the Vaccine Adverse Event Reporting System (VAERS).
- Investigational drugs or medical devices (those being studied) – report problems to your doctor or to the contact person listed in the clinical trial.

Will the information I report be kept private?

The FDA recognizes that privacy is an important concern, so you should know:

- We ask only for the name and contact information of the person filling out the form in case we need more information.
- Your name and contact information may be shared with the company that makes the product to help them better understand the problem you are reporting, unless you request otherwise (see Section F).

What types of products should I use this form for?

- Drugs, including prescription or over-the-counter medicines, and biologics, such as human cells and tissues used for transplantation (for example, tendons, ligaments, and bone) and gene therapies

- Medical devices, including any health-related kit, test, tool, or piece of equipment (such as breast implants, pacemakers, diabetes glucose-test kits, hearing aids, breast pumps, and many others)
- Cosmetics such as moisturizers, makeup, shampoos and conditioners, face and body washes, deodorants, nail care products, hair dyes and relaxers, and tattoos
- Foods (including beverages and ingredients added to foods)

Are there specific instructions for filling out the form?

- Fill in as much information as possible and send in the report even if you do not have all the information.
- You can fill out this form yourself or have someone fill it out for you. If you need help, you may want to talk with your health professional.
- Feel free to include or attach an image of the product. Please do not send the products to the FDA.

How will I know the FDA has received my form?

- You will receive a reply from the FDA after we receive your report. We will personally contact you only if we need additional information.
- Your report will become part of a database so that it can be reviewed and compared to other reports by an FDA safety evaluator who will determine what steps to take.

How can I contact the FDA if I have questions?

Toll-free line: 1-800-332-1088

To report online: www.fda.gov/medwatch/report.htm

The information below applies only to requirements of the Paperwork Reduction Act of 1995.

The burden time for this collection of information is estimated to average 30 minutes per response, including the time to review instructions, search existing data sources, gather and maintain the data needed and complete and review the collection of information. Send comments regarding this burden estimate or any other aspect of this information collection, including suggestions for reducing this burden to the address to the right:


OMB Statement: "An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB number."


Department of Health and Human Services
Food and Drug Administration
Office of Chief Information Officer
Paperwork Reduction Act (PRA) Staff
PRAStaff@fda.hhs.gov

DO NOT SEND YOUR COMPLETED FORM TO THIS PRA STAFF ADDRESS.

	DEPARTMENT OF HEALTH AND HUMAN SERVICES Food and Drug Administration MEDWATCH Consumer Voluntary Reporting (FORM FDA 3500B)	Form Approved: OMB No. 0910-0291 Expiration Date: 9/30/2018 <i>(See PRA Statement on preceding general information page)</i>
-----------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------


Note: For date prompts of "dd-mmm-yyyy" please use 2-digit day, 3-letter month abbreviation, and 4-digit year; for example, 01-Jul-2018.

Section A – About the Problem																	
<p>1. What kind of problem was it? <i>(Check all that apply)</i></p> <p><input type="checkbox"/> Were hurt or had a bad side effect <i>(including new or worsening symptoms)</i></p> <p><input type="checkbox"/> Used a product incorrectly which could have or led to a problem</p> <p><input type="checkbox"/> Noticed a problem with the quality of the product</p> <p><input type="checkbox"/> Had problems after switching from one product maker to another maker</p>	<p>2. Did any of the following happen? <i>(Check all that apply)</i></p> <p><input type="checkbox"/> Hospitalization – admitted or stayed longer</p> <p><input type="checkbox"/> Required help to prevent permanent harm</p> <p><input type="checkbox"/> Disability or health problem</p> <p><input type="checkbox"/> Birth defect</p> <p><input type="checkbox"/> Life-threatening</p> <p><input type="checkbox"/> Death <i>(include date)(dd-mmm-yyyy)</i>: - - </p> <p><input type="checkbox"/> Other serious/important medical incident <i>(Please describe below)</i></p> <div style="border: 1px solid #ccc; height: 40px; width: 100%;"></div>																
<p>3. Date the problem occurred <i>(dd-mmm-yyyy)</i></p> <p style="text-align: center;">- - -</p>		<p>4. Tell us what happened and how it happened. <i>(Include as many details as possible FDA may reach out to you for any additional documents if necessary)</i></p> <div style="border: 1px solid #ccc; height: 50px; width: 100%;"></div> <div style="text-align: right; border: 1px solid #ccc; padding: 2px; font-size: 8px;">Continuation Page</div>															
<p>5. Relevant Tests/Laboratory Data</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 20%; text-align: center;">Date <i>(dd-mmm-yyyy)</i></th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>		Date <i>(dd-mmm-yyyy)</i>							<p>Relevant Tests/Laboratory Data</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 20%; text-align: center;">Date <i>(dd-mmm-yyyy)</i></th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>		Date <i>(dd-mmm-yyyy)</i>						
	Date <i>(dd-mmm-yyyy)</i>																
	Date <i>(dd-mmm-yyyy)</i>																
<p>Additional Comments</p> <div style="border: 1px solid #ccc; height: 60px; width: 100%;"></div>																	
<p><i>For a problem with a product, including</i></p> <ul style="list-style-type: none"> prescription or over-the-counter medicine biologics, such as blood transfusions, gene therapies, and human cells and tissue transplants (for example, tendons, bone, and corneas) nutrition products, such as vitamins and minerals, herbal remedies, infant formulas, and medical foods cosmetics or make-up products foods (including beverages and ingredients added to foods) <div style="text-align: right; margin-top: 10px;">  Go to Section C </div>																	

Section A – About the Problem <i>(continued)</i>	
<p>For a problem with a medical device, including</p> <ul style="list-style-type: none"> • any health-related test, tool, or piece of equipment • health-related kits, such as glucose monitoring kits or blood pressure cuffs • implants, such as breast implants, pacemakers, or catheters • other consumer health products, such as contact lenses, hearing aids, and breast pumps 	 Go to Section D (Skip Section C)

For more information, visit http://www.fda.gov/MedWatch	Submission of a report does not constitute an admission that medical personnel or the product caused or contributed to the event.
---------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------

Section B – Product Availability	
1. Do you still have the product in case we need to evaluate it? <i>(Do not send the product to FDA. We will contact you directly if we need it.)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	2. Do you have a picture of the product? <i>(check yes if you are including a picture)</i> <input type="checkbox"/> Yes

Section C – About the Products			
1. This report is about <input type="checkbox"/> Drug <input type="checkbox"/> Cosmetic, Dietary Supplement or Food/Medical Food			
2. Name(s) of the product as it appears on the box, bottle, or package <i>(Include as many names as you see)</i> <div style="background-color: #e6f2ff; height: 15px;"></div>			
3. Check if therapy is on-going <input type="checkbox"/>			
4. Name(s) of the company that makes (or compounds) the product <div style="background-color: #e6f2ff; height: 15px;"></div>			
5. Product Type <i>(check all that apply)</i> <input type="checkbox"/> Over-the-Counter <input type="checkbox"/> Compounded by a Pharmacy or an Outsourcing Facility <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar			
6. Expiration date <i>(dd-mmm-yyyy)</i> <div style="background-color: #e6f2ff; width: 100px; height: 15px;"></div>	7. Lot number <div style="background-color: #e6f2ff; width: 100px; height: 15px;"></div>	8. NDC number <div style="background-color: #e6f2ff; width: 100px; height: 15px;"></div>	
9. Strength <i>(for example, 250 mg per 500 mL or 1 g)</i> <div style="background-color: #e6f2ff; width: 100px; height: 15px;"></div>	10. Quantity <i>(for example, 2 pills, 2 puffs, or 1 teaspoon, etc.)</i> <div style="background-color: #e6f2ff; width: 100px; height: 15px;"></div>	11. Frequency <i>(for example, twice daily or at bedtime)</i> <div style="background-color: #e6f2ff; width: 100px; height: 15px;"></div>	12. How was it taken or used <i>(for example, by mouth, injection, or on the skin)?</i> <div style="background-color: #e6f2ff; width: 100px; height: 15px;"></div>
13a. Date the person first started taking or using the product <i>(dd-mmm-yyyy)</i> : <div style="background-color: #e6f2ff; width: 100px; height: 15px;"></div>	13b. Date the person stopped taking or using the product <i>(dd-mmm-yyyy)</i> : <div style="background-color: #e6f2ff; width: 100px; height: 15px;"></div>	15. Why was the person using the product? <i>(such as, what condition was it supposed to treat)</i> <div style="background-color: #e6f2ff; height: 60px;"></div>	
14. Give best estimate of duration <div style="background-color: #e6f2ff; width: 100%; height: 15px;"></div>		16. Did the problem stop after the person reduced the dose or stopped taking or using the product? <input type="checkbox"/> Yes <input type="checkbox"/> No	
17. Did the problem return if the person started taking or using the product again? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Didn't restart		<div style="background-color: #e6f2ff; width: 100%; height: 15px;"></div>  Go to Section E (Skip Section D)	

For more information, visit http://www.fda.gov/MedWatch	Submission of a report does not constitute an admission that medical personnel or the product caused or contributed to the event.
---------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------

Section D – About the Medical Device					
1. Name of medical device					
2. Name of the company that makes the medical device					
3. Model number	4. Catalog number	5. Lot number	6. Serial number	7. UDI number	8. Expiration date (dd-mmm-yyyy)
					- -
9. Was someone operating the medical device when the problem occurred?					
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> The person who had the problem <input type="checkbox"/> A health professional (such as a doctor, nurse, or aide)					
<input type="checkbox"/> Someone else (Please explain who)					
10. For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)					
Date the implant was put in (dd-mmm-yyyy)					
Date the implant was taken out (if relevant) (dd-mmm-yyyy)					
<input type="checkbox"/> Go to Section E					

Section E – About the Person Who Had the Problem			
1. Person's Initials	2. Gender	3. Age (specify unit of time for age)	4. Date of Birth (dd-mmm-yyyy)
	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Intersex <input type="checkbox"/> Transgender <input type="checkbox"/> Prefer not to disclose	<input type="checkbox"/> Year(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Day(s)	- -
5. Weight (Specify lbs or kg)	6. Ethnicity (Choose only one)	7. Race (Choose all that apply)	
<input type="checkbox"/> lb <input type="checkbox"/> kg	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian	
8. List known medical conditions. (Such as diabetes, high blood pressure, cancer, heart disease, or others)			
9. Please list all allergies (such as to drugs, foods, pollen or others)			
10. List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)			
11. List all current prescription medications and medical devices being used.			
<input type="button" value="Continuation Page"/>			
12. List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.			
<input type="button" value="Continuation Page"/>			
<input type="checkbox"/> Go to Section F			

For more information, visit <http://www.fda.gov/MedWatch>

Submission of a report does not constitute an admission that medical personnel or the product caused or contributed to the event.

Section F – About the Person Filling Out This Form		
We will contact you only if we need additional information.		
1. Last name		2. First name
3. Number/Street		4. City and State/Province
5. ZIP or Postal code		6. Country
7. Telephone number	8. Email address	9. Today's date (dd-mmm-yyyy)
10. Did you report this problem to the company that makes the product (the manufacturer/compounder)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
11. If you do NOT want your identity disclosed to the manufacturer, place an "X" in this box: <input type="checkbox"/>		

Send This Report by Mail or Fax

Keep the product in case the FDA wants to contact you for more information. Please do not send products to the FDA. Mail or fax the form to: MedWatch, Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20852; FAX: 800-332-0178 (toll-free).

Thank you for helping us protect the public health.

For more information, visit http://www.fda.gov/MedWatch	Submission of a report does not constitute an admission that medical personnel or the product caused or contributed to the event.
---------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------

Continued Entries	
<p>CONTINUED ENTRY FOR: Tell us what happened and how it happened. <i>(Include as many details as possible)</i></p>	
	Back to Form
<p>CONTINUED ENTRY FOR: List all current prescription medications and medical devices being used.</p>	
	Back to Form
<p>CONTINUED ENTRY FOR: List all over-the-counter medications and any vitamins, minerals, and herbal remedies being used.</p>	
	Back to Form