

University of Texas Medical Branch at Galveston

Value Analysis Product/Device Evaluation Request Form

In order for this form to be considered by a Value Analysis Committee/Team:

- a. The form must be completed in its entirety (evaluation page 1 only, purchase page 1 & 2).
b. A representative from the requesting area must be present at a Value Analysis/Cost Management Team meeting.
c. All approval signatures must be obtained.

Date: _____ Request to: Evaluate _____ Purchase _____ product/device.

Table with 2 columns and 3 rows: Name of Product/Device, Manufacturer; Manufacturer Catalog Number, Cost of Product/Device; Anticipated Annual Usage, Reimbursement Code (HCPCS/CPT Code)

CLINICAL IMPACT STATEMENT: What improvements to patient care and/or cost reductions are anticipated? Briefly Describe this product/device and clinical impact (also, describe other required components/accessories if applicable):

IS THERE A PRODUCT/DEVICE AT UTMB PERFORMING THE SAME FUNCTION? Yes ___ No ___

If yes, what product(s)/device(s) description, manufacturer, MM# & catalog # performs the same function as the requested product/device?

If no, why is it necessary to introduce and use this new product/device?

WHAT OTHER DEPARTMENT(S) WILL USE AND/OR BE AFFECTED BY THIS PRODUCT/DEVICE?

If replacing another item ,please attach a Cost Analysis Form for the requested product(s)/device(s)

Disclose any special relationship with the vendor:

Please affirm that:

The requestor does not directly or indirectly have any financial or personal interest (e.g., equity ownership, compensated positions on advisory boards, a paid consultancy or other forms of compensated relationship) in the company or their employees that might benefit from the institutional decision. (IHOP 6.1.1)

The requestor does not have a relationship with an employee, a partner, a major stockholder, a paid consultant with the Vendor under consideration, or other owner of the business entity that is related.

Signatures: (All signatures MUST be obtained)

Requester: _____ Account # _____ Ext: _____

Department Head/Committee Chair: _____ Date: _____

Executive Director: _____ Date: _____

Please attach manufacturer's specification, sales literature and representative's business cards.

If desiring to purchase the requested product/device, please complete the remainder of the form.

LIST TWO (2) OTHER MANUFACTURERS OF PRODUCT/DEVICE REQUESTED:

Manufacturer

Catalog#

List Price

A.

B.

If no other product or manufacturer is available or acceptable, please attach Sole Source/Proprietary Justification form

Will this item be stocked in the Omnicell Units? Yes ____ No ____

What is the anticipated annual usage volume of this product?

Will there be additional implementation costs, such as installation, cost of education, impact on equipment?
Yes ____ No ____ If yes, please describe

How will this item be issued? Each ____ Box ____ Package ____ Case ____ Other ____

Is the requested product(s)/device(s):

Latex Free Yes ____ No ____ Patient Chargeable? Yes ____ No ____

Urgently Required Yes ____ No ____ If yes, why and how soon?

Under a current contract? Yes ____ No ____ If yes, what contract?

Need medical staff notification? Yes ____ No ____

If yes,

Name: _____ Dept: _____ Ext: _____

VALUE ANALYSIS USE ONLY

Product requested in past? YES NO If yes, what was the date of request?

Presented/reviewed on: _____ to _____ Cost Management Team/JPECT.

Evaluate

Not Evaluate

Approved

REQUIRED FURTHER ACTION:

Signature: _____ Date: _____

Team Facilitator or VAF

MMIS #: _____

MATERIALS MANAGEMENT POLICY FOR STOCKED ITEMS

1. Items that are approved and accepted as stock items in Materials Management Inventory and not utilized for a period of 6 months will be automatically charged to the account number listed above and removed from inventory.
2. After an item has been approved by Value Analysis, as an inventory item it may take 15-30 days for the item to be available.

PLEASE FORWARD COMPLETED FORM TO PAULA TOWNLEY, RT 0467