COLUMBIA UNIVERSITY MEDICAL CENTER

CUMC Research Pharmacy
17 Smith Street
Englewood, NJ 07631
201.568.6315 Tel
201.568.6148 Fax
www.researchpharmacy.org

KIT PACKAGING COST ESTIMATE REQUEST FORM

Please complete the entire form so the Research Pharmacy may provide you with a kit packaging plan and cost estimate. Return the completed form to researchpharmacy@columbia.edu ***as an e-mail attachment or fax to 201-568-6148.***

IRB # ________________________________ *(if available)*

Contact Information:

Investigator:___________________________Department:______________________________

Phone:_______________________________________Fax:____________________________

E-mail: _______________________________________

Coordinator:___________________________________Phone:__________________________

Fax:____________________________E-mail:____

Study Title:____

____

Study Description: ____

____

____

Number of Sites: ___________

Total Number of Patients: __________

Comment: ____

____

Randomization:

☐ There is no randomization

☐ Randomization will be generated by the sponsor or Investigator

☐ Randomization code will be generated by the Research Pharmacy

Describe Randomization Scheme:

____

____

Describe Treatment Groups:

1- ____________________

2- ____________________

3- ____________________

4- ____________________

Kit containing clinical supplies:

Describe Kit: ____
____
____

Services requested: **(check all that apply)**

Manufacture: ☐Capsules ☐ Ointment/Cream ☐Other______________________

Capsule Filler: ☐Lactose ☐ Riboflavin ☐ Microcrystalline Cellulose

☐Placebo Tablet ☐ Other_____________________ ☐ None

Dosing Schedule:

Label Instructions: ex. *Take 1 tablet twice a day, as directed by MD.*

____

____

Treatment 1: ______________________
Name of Drug

Please fill in all that applies to the study. If your study design does not fit well into this table, please make a table and attach.									
Study Day									
Visit #	0	1	2	3	4	5	6	7	8
# of Bottles									
# of Tablets in Bottle									
# of Dose per Day									
# of Capsules per Day									
Time Doses are Taken Daily									

Treatment 2: ______________________
Name of Drug

Please fill in all that applies to the study. If your study design does not fit well into this table, please make a table and attach.									
Study Day									
Visit #	0	1	2	3	4	5	6	7	8
# of Bottles									
# of Tablets in Bottle									
# of Dose per Day									
# of Capsules per Day									
Time Doses are Taken Daily									

Treatment 3: ______________________
Name of Drug

Please fill in all that applies to the study. If your study design does not fit well into this table, please make a table and attach.									
Study Day									
Visit #	0	1	2	3	4	5	6	7	8
# of Bottles									
# of Tablets in Bottle									
# of Dose per Day									
# of Capsules per Day									
Time Doses are Taken Daily									

Treatment 4: ______________________
Name of Drug

Please fill in all that applies to the study. If your study design does not fit well into this table, please make a table and attach.									
Study Day									
Visit #	0	1	2	3	4	5	6	7	8
# of Bottles									
# of Tablets in Bottle									
# of Dose per Day									
# of Capsules per Day									
Time Doses are Taken Daily									

Drug Description:

Study Drugs: (include both investigational agents and any FDA approved products that will be provided in the kit)

____

____

Study drug provider: ☐ Sponsor ☐ Investigator

☐ Drug will be purchased via the pharmacy

Sponsor Contact: ____

____

____

Describe Formulation*:*

☐ Capsules ☐Tablets ☐Vials ☐ Bulk (Requires Packaging/Labeling/Dispensing)

Drug shipment from the Research Pharmacy will be to:

☐ Investigator/Coordinator ☐Sites