SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

Request for Change Form

THE REQUESTED CHANGE WILL (PRIMARILY) EFFECT:

☐ Drug Formulary ☐ Device ☐ Procedure

☐ Protocol ☐ Scope of Practice

THE REQUESTED CHANGE WILL INVOLVE:

☐ Addition or Expansion ☐ Change in Use ☐ Deletion or Restriction

INITIAL COMMITTEE FOR REVIEW:

☐ EMS-C ☐ Medical Control Committee ☐ Trauma Advisory Committee

☐ Stroke Advisory Committee ☐ EMS Advisory Council

DRUG FORMULARY CHANGE REQUEST:

1. Generic Name:
2. Trade Name:
3. How Supplied:
4. Proposed Methods of Administration:
5. Indications for Administration:
6. Contraindications for Use:
7. Recognized Side Effects and/or Adverse Reactions:
8. Therapeutic Effects:
9. Adults Dosage:
10. Pediatric Dosage:
11. Is there an age range for this drug?
12. Note: Is the proposed use of the DRUG approved by the FDA? ☐ YES ☐ NO
13. Reason for Recommendation: [Include similar agents already approved and why the new agent is recommended in favor of current medications.]
14. Advantages of Adding/Deleting This Drug:
15. What Protocols are Affected by Addition/Deletion of this Drug:
16. Literature Supporting This Change in Formulary in the Pre-Hospital EMS Setting:

4483-ENG-DPH (05/2025)

DEVICE CHANGE REQUEST:

1. Device Name:
2. Device Function:
3. Indications for Use:
4. Contraindications for Use:
5. Recognized Side Effects and/or Adverse Reactions:
6. Therapeutic Effects:
7. Adult Usage Criteria and Methods:
8. Pediatric Usage Criteria and Methods:
9. Is there an age restriction on this device?
10. Note: Is the proposed use of the device approved by the FDA? ☐ YES ☐ NO
11. Reason for Recommendation: [Include similar devices already approved and why the new device is recommended in favor of currently approved device/s]
12. Advantages of Adding/Deleting This Device:
13. What Protocols Are Affected by Addition/Deletion of This Device:
14. What Type and Frequency of Recurrency Training is Recommended/Suggested to Insure Continued Competence with This Procedure:
15. Cost Estimates to Purchase, Train, Test, and Provide Recurrency Training:
    a. Cost to Acquire:
    b. Cost of Initial Training:
    c. Cost of Recurrency Training and Frequency:
    d. Cost of Maintenance and Upkeep if Indicated:
16. What Method of Training Will be Employed to Educate the Personnel Who Are Affected:
    a. Planned Hours of Training to be Required:
    b. Proposed Outline and Curriculum for Training:
17. Literature Supporting This Change in Device Usage in the Pre-Hospital EMS Setting:

PROCEDURE CHANGE REQUEST:

1. Procedure Name:
2. Procedure Function:
3. Indications for Use:
4. Contraindications for Use:
5. Recognized Side Effects and/or Adverse Reactions:
6. Therapeutic Effects:
7. Adult Usage Criteria and Methods:
8. Pediatric Usage Criteria and Methods:
9. Is there an age restriction on this procedure?
10. Note: Is the proposed use of the procedure approved by the FDA? ☐ YES ☐ NO
11. Reason for Recommendation: [Include similar procedures already approved and why the new procedure is recommended in favor of currently approved procedure/s]
12. Advantages of Adding/Deleting This Procedure:
13. What Protocols Are Affected by Addition/Deletion of This Procedure:
14. What Type and Frequency of Recurrency Training is Recommended/Suggested to Insure Continued Competence with This Procedure:
15. Cost Estimates to Purchase, Train, Test, and Provide Recurrency Training:
    a. Cost to Acquire:
    b. Cost of Initial Training:
    c. Cost of Recurrency Training and Frequency:
    d. Cost of Maintenance and Upkeep if Indicated:
16. What Method of Training Will be Employed to Educate the Personnel Who Are Affected:
    a. Planned Hours of Training to be Required:
    b. Proposed Outline and Curriculum for Training:
17. Literature Supporting This Change in Procedure Usage in the Pre-Hospital EMS Setting:

PROTOCOL CHANGE REQUEST:

1. Protocol Name and ID Number [if referencing a Current SC Prehospital Protocol]:
2. Protocol Function:
3. Indications for Use:
4. Contraindications for Use:
5. Adult Protocol Changes (if necessary):
6. Pediatric Protocol Changes (if necessary):
7. Is there an age restriction on this procedure?
8. Reason for Recommendation [Include why the currently approved protocol (if such exists) should be changed and why the new protocol change is recommended in favor of currently approved protocol/s]:
9. Advantages of Adding/Deleting This Protocol:
10. What Protocols Are Affected by Addition/Deletion of This Procedure [address both Adult and Pediatric Protocols]:
11. What Type and Frequency of Recurrency Training is Recommended/Suggested to Insure Continued Competence with This Protocol:
12. Cost Estimates to Purchase, Train, Test, and Provide Recurrency Training:
    a. Cost to Acquire:
    b. Cost of Initial Training:
    c. Cost of Recurrency Training and Frequency:
    d. Cost of Maintenance and Upkeep if Indicated:
13. What Method of Training Will be Employed to Educate the Personnel Who Are Affected:
    a. Planned Hours of Training to be Required:
    b. Proposed Outline and Curriculum for Training:
14. Literature Supporting This Change in Protocol Usage in the Pre-Hospital EMS Setting:

SCOPE OF PRACTICE CHANGE REQUEST:

1. Level of Certification/s for Requested Change in Scope of Practice

☐ EMR ☐ EMT-B ☐ EMT-A ☐ EMT-P

☐ EMT-CP ☐ EMT-CC ☐ EMT-TM ☐ EMT-FM

2. Current Scope of Practice for Specific Level/s That Are Being Considered for Change:

3. Recommended Change in Scope of Practice for Specific Level/s That Are Being Considered for Change [Will the requested change effect different levels differently – e.g. Is the request for change ONLY going to affect the EMT-TM or EMT-FM – but NOT CHANGE the Scope of Practice for the EMT-P or EMT-CP, etc. Would the change effect only the EMT-A – but is already approved at the EMT-P level, etc.]

4. Adult Protocol Changes (if necessary):

5. Pediatric Protocol Changes (if necessary):

6. Is there an age restriction on this change in Scope of Practice?

7. Reason for Recommendation [Include why the currently approved scope practice (for this activity) should be changed and why the new scope of practice change is recommended in favor of currently approved Level Specific Scope of Practice]:

8. Advantages of Adding/Deleting/Changing This Scope of Practice:

9. What Protocols Are Affected by Addition/Deletion of This Scope of Practice [address both Adult and Pediatric Protocols]:

10. What Type and Frequency of Recurrency Training is Recommended/Suggested to Insure Continued Competence with This Changed Scope of Practice:

11. Cost Estimates to Purchase, Train, Test, and Provide Recurrency Training:
    a. Cost to Acquire:
    b. Cost of Initial Training:
    c. Cost of Recurrency Training and Frequency:
    d. Cost of Maintenance and Upkeep if Indicated:

12. What Method of Training Will be Employed to Educate the Personnel Who Are Affected:
    a. Planned Hours of Training to be Required:
    b. Proposed Outline and Curriculum for Training:

13. Literature Supporting This Change in Scope of Practice in the Pre-Hospital EMS Setting:

THE ABOVE REQUESTED CHANGE IS REQUESTED BY [ALL MUST BE COMPLETED]:

1. Name of EMS Service:
2. Signature of EMS Service Administrative Director:
3. Signature of EMS Service Medical Control Physician:
4. Signature of Regional EMS Medical Director:

THIS REQUESTED CHANGE WILL BE FORWARDED TO [CHECK ALL THAT APPLY]:

☐ Director, DPH EMS & Trauma Section

☐ State Medical Control Physician

☐ Assistant State Medical Control Physician

***NOTE:**

The EMS & Trauma Section Medical Control Committee reviews the Prehospital Formulary Annually in the Spring. Formulary changes are only considered at that time – with the exception of cases where there is Emergent need to consider a change outside of this schedule (e.g. Drug Recall, Drug Shortage, Immediate change in Standard of Care). Temporary approval of formulary changes MAY be approved prior to full Medical Control Committee review in extenuating circumstances – but such approval will continue, at maximum, until the Annual Formulary Review by the Medical Control Committee.

Other committees will determine the schedule for which Policies, Protocols, Procedures, Devices, and Scope of Practice are reviewed by those committees. This determination will be made by the committee of jurisdiction for the issue in question.

This application should be completed in full. Incomplete applications may be significantly delayed for committee review. The Requesting Agency/Medical Control Physician should address how any change will affect adults as compared to pediatrics; what costs are involved in acquisition, training, replacement, recurrency training, etc.; the planned educational format and curriculum; and should provide current literature that supports the recommended change in the prehospital EMS setting.

Request for Change Form

Instructions for Completing 4483-ENG-DPH

PURPOSE: To request changes in the Drug Formulary, a device, procedure, protocol, or Scope of Practice, which includes addition or expansions, changes in use, and deletions or restrictions.

AUDIENCE: The EMS Service, with the signature of the EMS Service Administrative Director and the EMS Service Medical Control Physician.

INSTRUCTIONS: Complete applicable sections and supply the requested information.

OFFICE MECHANICS & FILING: Once reviewed and approved or disapproved by the committee(s), this form should be scanned and placed into the agency's electronic profile in the state database. This form is maintained by 10010 — Licensed Provider Files. Once the file is no longer needed for reference and quality review has been completed, an ARM-11 destruction request should be submitted and approved prior to disposal of the original form.