

INITIATOR (Note, after entering the initial information, you must save the document under a new name)

Requester: _____	Division/Office: _____
Phone: _____	Date (m/d/yy) : _____

SECTION I – SUMMARY REQUEST (Initiator)

Product Name: _____	Mfr. Item Product Code # (not NDC/UPC): _____
Supplier Name: _____	NDC (5-4-2 Format) _____ *UPC/HRI# _____
Supplier #: _____ (Dist) _____ (Star)	Item: _____ Inner: _____ Case: _____
Strength: _____	*(leading 0, 3, 6, 7, 8 or 9 followed by 10 digits – Do not include check digit.)
Form (tablet, capsule, etc.): _____	
Size (oz, ml, pieces, etc.): _____	Drop Ships Only? <input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol Free: <input type="checkbox"/> Yes <input type="checkbox"/> No	Equivalent to: _____
Sugar Free: <input type="checkbox"/> Yes <input type="checkbox"/> No	Orange Book Code: _____
Scent/Flavor: _____	Bar-Coded: <input type="checkbox"/> Yes <input type="checkbox"/> No Unit Dose: <input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION II – BUSINESS REASON/CASE (Initiator)

1. Are alternatives/comparable products stocked at Division? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, Item #'s _____
2. What is volume (in units/month) expected? _____	
3. When is product needed to be in stock? _____	
4. Where is product to be stocked (list by Natl, Region, Div)? _____	
5a. Is a customer interested in carrying the product? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, Customer's Name _____
5b. Is there a contractual obligation to carry the product? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Is this product part of a group (>20 Items) of products that are being added at the same time? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, use the group add process	

New Product Add Form (Single Item)v2000

SECTION III – DETAILED PRODUCT INFORMATION (Category Manager)

Product Category	Pack Type	Storage Codes	
<input type="checkbox"/> HBA	<input type="checkbox"/> Bonus Size	<input type="checkbox"/> 01 Aerosol	<input type="checkbox"/> 13 Carcinogenic
<input type="checkbox"/> OTC	<input type="checkbox"/> Cents Off	<input type="checkbox"/> 02 Alcohol	<input type="checkbox"/> 14 Avoid Excessive Heat > 104?
<input type="checkbox"/> General Merchandise	<input type="checkbox"/> Counter Unit	<input type="checkbox"/> 03 Refrigerator	<input type="checkbox"/> 15 Radioactive
<input type="checkbox"/> Medical Supply	<input type="checkbox"/> In-Store Redeemable Coupon	<input type="checkbox"/> 04 Cage	<input type="checkbox"/> 16 Oxidizer
<input type="checkbox"/> RX	<input type="checkbox"/> Trial Size	<input type="checkbox"/> 05 Vault	<input type="checkbox"/> Flammable Liquid
<input type="checkbox"/> RX – C2 Reportable	<input type="checkbox"/> Twin Pack	<input type="checkbox"/> 06 Flammable/Plastics	<input type="checkbox"/> Flammable Solid
<input type="checkbox"/> RX – C3 Non-Reportable	<input type="checkbox"/> Floorstand Deal	<input type="checkbox"/> 07 Store under Controlled Room Temperature - below 75?	<input type="checkbox"/> Corrosive Material
<input type="checkbox"/> RX – C3 Reportable	<input type="checkbox"/> Pre-priced	<input type="checkbox"/> 08 Store Under Refrigeration	<input type="checkbox"/> Irritating Material
<input type="checkbox"/> RX – C4	<input type="checkbox"/> Shelf-extender	<input type="checkbox"/> 09 Refrigerate/Do Not Freeze	<input type="checkbox"/> Oxidizing Material
<input type="checkbox"/> RX – C5	<input type="checkbox"/> Drop Shipped ONLY	<input type="checkbox"/> 10 Do Not Freeze	<input type="checkbox"/> Poison Liquid or Solid Class B
<input type="checkbox"/> Other _____	<input type="checkbox"/> Unit Dose	<input type="checkbox"/> 11 Keep Frozen	
	<input type="checkbox"/> Other _____	<input type="checkbox"/> 12 Store & Ship Frozen	

SECTION IV – COST (Category Manager or Supplier)

	Bracket#	Qty Break (Sell Units)	Cost (Sell Units)	Unit (Sell Units)
Regular Wholesale Cost _____ per _____ (U of M)				
Regular Sell Unit Cost _____ per _____ (U of M)	1	_____	_____	_____
Manufacturer's Suggest AWP (if any) _____	2	_____	_____	_____
Manufacturer's Suggested Retail Price (if any) _____	3	_____	_____	_____
Master Case Qty _____ Inner Pack Qty _____	4	_____	_____	_____
Order Minimum (item) _____ (U of M) _____ (e.g. ea, cs, dz.,)	5	_____	_____	_____

SECTION V – PHYSICAL CHARACTERISTICS (Category Manager or Supplier)

Individual Item Dimensions:		Individual Item Weight:	
_____ "x" _____ "x" _____ "	H	W	L/D
		_____ lbs	_____ oz
Inner Pack Dimensions:		Case Pack Weight:	
_____ "x" _____ "x" _____ "	H	W	L/D
		_____ lbs	_____ oz
Master Case Dimensions:		Unit Load Weight:	
_____ "x" _____ "x" _____ "	H	W	L/D
		_____ lbs	_____ oz
COF (Cube Order Factor): _____			

SECTION VI – DEAL/PROMOTIONAL INFORMATION (Category Manager or Supplier)

DEAL CONTENTS			
All deals must have a complete listing of contents, including individual UPC/NDC numbers and costs (e.g. Floorstand, Dealbreak)			
Retail Unit NDC/UPC/HRI#	Description	Qty	Item Standard Cost
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____
6	_____	_____	_____

New Product Add Form (Single Item)v2000

PROMOTIONAL INFORMATION			
Estimated Ship Date:	_____	Promotional Dating:	_____
Buy Period From:	_____	To:	_____
Number of Buys:	_____	Ship Period From:	_____
Off Invoice (\$/Unit, %off):	_____	Bill Back Unit/% off:	_____
Off-Invoice Start:	_____	End:	_____

Does this item contain any of the following chemicals? (REQUIRED)				Example:
Phenylpropanolamine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Qty	_____	25MG
Pseudoephedrine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Qty	_____	30MG
Ephedrine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Qty	_____	75MG/ML

SECTION VII – ABC USE ONLY (Category Manager)

AAS/BBC Number: _____ (Dist) _____ (Star)	Programs
Supplier Number: _____ (Dist) _____ (Star)	<input type="checkbox"/> PRO Generics Item
Supplier Name: _____	<input type="checkbox"/> PRO Rx
Cat/Inv Manager: _____	<input type="checkbox"/> Home Health Care Prgm Item
Purchase Unit: _____	<input type="checkbox"/> HBC Source
Wholesale Unit: _____	<input type="checkbox"/> Other Special Program Specify _____
Corp Order Mult: _____	
<input type="checkbox"/> Suppress from Microfiche <input type="checkbox"/> Suppress from AccuSource <input type="checkbox"/> Net Pricing: _____ % MU _____ S/N Price <input type="checkbox"/> Fine Line Code (Must be filled out): _____ (Dist) _____ (Star) Private Label Code: _____ Inv. Class: _____ CRV: _____ IFC Only: _____ Replacement Item for AAS/BBC#: _____ (Dist) _____ (Star) Delete <input type="checkbox"/> Yes <input type="checkbox"/> No Replacement Item Effective Date: _____	
HBC SOURCE	
Cost _____	Net Sell _____
Zone 1 _____	Zone 2 _____
Zone 3 _____	A Dist Qty _____

CODES REFERENCE

Unit of Measure	Forms
CS = Case	AM AMPULES
EA = Each	BG BAG
PK = Pack	CL CAPLET
DL = Deal	CP CAPSULE
	CR CREAM
	CY CRYSTALS
	DR DROPS
	EL ELIXIR
	GC GELCAP
	GL GEL
	GN GRANULE
	GT GELTAB
	IH INHALER
	IV INJECTION
	JL JELLY
	KT KIT
	LG LIQUID GEL
	LO LOTION
	LQ LIQUID
	LT LIQUID TAB
	OT OINTMENT
	PD POWDER
	PH PATCH
	PK PACKETS
	SG SOFT GEL
	SL SOLUTION
	SP SUPPOSITORY
	SR SYRUP
	SU SUSPENSION
	SY SYRINGE
	TB TABLET
	VL VIAL