IEHP Medicare DualChoice HMO SNP / IEHP DualChoice (Medicare – Medi-Cal)

REQUEST FOR ADDITION OR DELETION OF A DRUG TO THE FORMULARY

GENERIC NAME: ____________________________ **BRAND NAME:** ______________________________

MANUFACTURER(S): ____

DOSAGE FORM: ____

Pharmacological Classification: ____

Indications: ____

What similar drugs are currently available? ____

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What therapeutic advantage(s) does this drug have over the standard drug therapy? _____________________

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In how many patients do you expect this drug to be used during the next six months? _________________

What drug(s) currently used for this/these indications(s) may be deleted if this product is added to the formulary?

____ ____

____ ____

Should use of this drug be restricted to certain physicians or institutions because of the potential for misuse, high cost, or toxicity?____

REQUESTER'S NAME: ____

ADDRESS & TELEPHONE: ____

SIGNATURE OF REQUESTER: ___________________________________ **DATE:** ___________________