

Health Plan of San Joaquin Formulary Addition Request Form

Generic name: _____ Brand name: _____

Manufacturer(s): _____

Dosage form: _____ AWP: _____

Pharmacological Classification: _____

Indications: _____

What similar drugs are currently available? _____

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

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 indication(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? Yes _____ No _____

Requestor's name (please print): _____

Address: _____

Telephone: _____

Requestor Signature: _____ *Date:* _____

Fax to (209) 461-2458 or (209) 461-2409 or (209) 461-2481