



**L.A. Care Health Plan, Pharmacy & Therapeutics Committee
Formulary Drug Review Request**

Use this form to request an addition, deletion or re-evaluation of a specific drug. Send completed form to: L.A.Care Health Plan Attention Pharmacy & Formulary , 1055 West 7th Street 10th floor, Los Angeles, CA 90013. Please provide justification for formulary consideration. If you have questions or need more information, please call 888-522-7999

Your Name:	Telephone & Fax
Affiliation/IPA	Address
Drug Generic Name	Drug Trade Name/Strength(s)/Dosage forms/Mfg.
Your recommendation (please choose one) <input type="radio"/> Delete drug <input type="radio"/> Add drug without restrictions/guidelines <input type="radio"/> Add drug with restrictions/guidelines- please indicate restriction/guidelines	If you recommend deletion, please check reason, <input type="radio"/> New evidence drug is unsafe <input type="radio"/> An equivalent drug on the formulary is more effective <input type="radio"/> An equivalent drug on the formulary is less expensive Attach supporting documentation. Specify preferred drug

IF YOU RECOMMEND AN ADDITION, PROVIDE EVIDENCE BASED DOCUMENTATION TO SUPPORT THE FOLLOWING CRITERIA.

NEED- specify unique qualities of drug not shared by other formulary drugs

EFFECTIVENESS- drug is substantially more effective than similar drugs on the formulary

SAFETY PROFILE- drug is substantially safer than similar drugs on the formulary

FINANCIAL IMPACT- drug is substantially less costly than similar drugs on the formulary

Declaration and Signature:

I have no financial interest in this drug or the pharmaceutical company which manufacturers, distributes, or sells it. Or I will fully disclose any conflict of interest or potential conflict of interest with this request.

Physicians Signature: _____ Date: _____ License#: _____

Physicians Name (please print) _____ Reviewed by: _____