

# Pharmacy and Therapeutics Committee

Request for Formulary Review

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| --- | --- |
| Date |  |
| Requestor’s name |  |
| Requestor’s Phone/Fax# |  |
| Drug Name(Brand Name) |  |
| Drug Name(Generic Name) |  |
| Dosage Form(s)(If not tablet or capsule) |  |
| Indication(s) |  |
| Is there a similar drug on the Formulary? | Yes No If yes, list drug(s) below. |
| AWP of Drug(30 days supply) |  |
| Please provide supporting documentation for addition of the drug to the Formulary. |  |
| Comments |  |

Submit all completed forms to: Joseph Cardinalli, PharmD Pharmacy Director

Contra Costa Health Plan 595 Center Avenue, Suite 100 Martinez, CA 94553

Fax: 925-313-6412