Chart, waterfall chart

Description automatically generated

# Pharmacy and Therapeutics Committee

Request for Formulary Review

|  |  |
| --- | --- |
| 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