Print Form

SAN FRANCISCO HEALTH PLAN
Here for you
201 THIRD STREET, 7TH FLOOR
SAN FRANCISCO, CA 94103
www.sfhp.org

REQUEST FOR FORMULARY MODIFICATION

Fill out and return by FAX : SFHP Attention: Pharmacy Review (415) 547-7819

1. Name of requesting provider:	
2. Generic name of drug:	
3. Trade name:	
4. Dosage forms:	
5. Strengths:	
6. Comparable formulary drugs:	
7. Situations in which requested drug is superior:	
8. Which of the current formulary drugs may be deleted at the addition of the drug requested?	
9. Anticipated frequency of use (check one)	☐ Acute ☐ Other (Please Specify) ☐ Chronic
10. Approximately how many of your patients would be switched from a formulary medication to this medication being requested?	
11. References:	
12. Please list any studies that support the addition of this agent to the current formulary:	

13. Potential conflict of interest disclosure :
(check one and include comments, if applicable)

		Comments:
• I receive research support from manufacturer	**Y** ☐ **N** ☐	
• I have a consulting agreement with manufacturer	**Y** ☐ **N** ☐	
• I, spouse, dependent have a financial interest in the manufacture of this agent	**Y** ☐ **N** ☐	

.14. Signature: Date:

This request will be considered at the next Pharmacy & Therapeutics Committee Meeting