Print Form

SAN FRANCISCO HEALTH PLAN
Here for you

REQUEST FOR FORMULARY MODIFICATION

Fill out and return by FAX : SFHP
Attention: Pharmacy Review 1(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 anufacturer **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