Santa Clara Family Health Plan™

Pharmacy & Therapeutics Committee

Formulary Addition Request Form

***Note:* <u>*This form must be completed and signed by the requestor.*</u>** *All requests must be received by the SCFHP Pharmacy Department no later than 4 weeks prior to the next P&T Committee meeting. A written response will be provided to the requestor with the P&T decision after the review.*

Date of Request	**Requestor's Email Address**
Requestor's Name	**Requestor's Phone Number**
Requestor's Specialty	**Requestor's Fax Number**
Requestor's Mailing Address	**Requestor's Network Affiliation with SCFHP**

Drug Requested to Review (Brand Name)	**Drug Requested to Review (Generic Name)**
Dosage Form	**Strength**
FDA approved indications for use	
Other indications for which this agent is being used and/or studied (Describe the role of this agent in the management of these indications)	
Is there a similar drug on the SCFHP Formulary? ☐ Yes ☐ No If yes, please include the name of the medication	

Please provide rationale for addition of the drug to the formulary. Such as:

1. *Is it more efficacious than other formulary drugs?*
2. *Is it more/less toxic than other formulary drugs? Are there any other special cautions or side effects?*
3. *In how many patients do you expect this drug to be used during the next six months?*
4. *What drug(s) currently used for this/these indications(s) may be deleted if this product is added to the formulary?*
5. *Is it more/less costly than other formulary drugs?*
6. *Is it more/less cost-effective in lowering overall health care costs?*

Rationale:

Supporting Documentation: Please attach a related bibliography and copies of two pivotal studies from peer-reviewed literature that demonstrates superiority of this agent over others. Randomized controlled trials comparing the drug to other drugs used to treat the same disease states are preferred.

Potential Conflict of Interest Disclosure: (Attach comments if applicable):

☐ Yes ☐ No	In the past 24 months, have you or your practice received research support or other financial support from the manufacturer of this requested drug.
☐ Yes ☐ No	I have a consulting agreement with the manufacturer of this requested drug.
☐ Yes ☐ No	I, spouse, or a dependent have a financial interest in the manufacturer of this requested drug.

Requestor's Signature	Date

Please submit your request to:
Santa Clara Family Health Plan
ATTN: Pharmacy Department
PO Box 18880
San Jose, CA 95158
Or fax to 408-874-1961