Community HealthChoices | AmeriHealth Caritas Pennsylvania

Formulary Addition/Deletion/Modification or Comments on Pharmacy & Therapeutics (P&T) Meeting Agenda Items

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 affiliation with health plan:	

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 formulary? ☐ Yes ☐ No If yes, please include the name of the medication	

Please provide rationale for addition of the drug to the formulary. Use additional sheet(s) of paper as necessary.
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 the drug 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 relevant studies from peer-reviewed literature that demonstrate superiority of this agent over others. Randomized controlled trials comparing the drug to other drugs used to treat the same disease states are preferred.

Comments on upcoming P&T agenda item(s): Use additional sheet(s) of paper as necessary.

1. P&T meeting date and agenda item?

2. Comments and suggestions for committee consideration before voting occurs?

Potential conflict of interest disclosure. Check the boxes and attach comments if applicable.

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

Do you have a consulting agreement with the manufacturer of this requested drug? ◻ Yes ◻ No
Do you, your spouse, or your dependent have a financial interest in the manufacturer of this requested drug? ◻ Yes ◻ No

Requestor's signature:	Date:

Please send your request to:

PerformRx
P.O. Box 516
Essington, PA 19029

Or email to: **medicaidformulary@performrx.com**
Or fax to: **1-215-863-5100**