Keystone First

Community HealthChoices

P&T Committee Request Form for a Formulary/ Preferred Drug List Addition, Deletion, Modification, or Comments on P&T Meeting Agenda Items

Note: ALL components of this form must be completed by the requestor for a review. Use additional sheet(s) of paper if necessary. A written response will be provided to the requestor with the Pharmacy & Therapeutics (P&T) Committee decision after the review.

Please print — accuracy is important.

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 (e.g., physician, pharmacist, consumer):

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 the rationale for adding 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 indication(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?

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Rationale:

Supporting documentation: Please attach a related bibliography and copies of relevant 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.

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 (circle and 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, my spouse, or my dependent have a financial interest in the manufacturer of this requested drug.

Requestor's signature:	Date:

Please submit your request to:

PerformRx
P.O. Box 156
Essington, PA 19029
MedicaidFormulary@performrx.com

or fax to: **1-215-863-5100**