Presbyterian Health Plan, Inc.
Presbyterian Insurance Company, Inc.
Pharmacy and Therapeutics (P&T) Committee
Request Form for a Formulary/Preferred Drug List
Addition, Deletion or Modification

ALL components of this form must be completed by the requestor for a review. A written response will be provided to the requestor with P&T's 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:	

Drug requested for review (brand name):	Drug requested for review (generic name):
Dosage form:	Strength:

This medication should be reviewed for the following formularies (check all that apply):
Turquoise Care formulary ☐ Commercial 4-Tier formulary ☐ Metal Level Plan formulary ☐ Senior Care/Medicare formulary ☐

FDA-approved indications for use:

Other indications for which this drug is being used and/or studied:

Is there a similar drug on the formulary?
Yes ☐   No ☐   Unknown ☐ If yes, please include the name of the medication.

Please provide the rationale for adding the drug to the formulary.

List the therapeutic advantages and disadvantages of this drug over the formulary drugs that are used to treat the same medical condition(s):

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List any safety issues related to the use of this drug (i.e., side effects or any other special precautions):

List the anticipated frequency of use of the requested drug in your practice:

Is the drug more/less costly than other formulary drugs?

Supporting documentation: Please cite or attach published, peer-reviewed literature in support of the above statements.

Potential conflict of interest disclosure

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:

askphppt@phs.org

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