SAN DIEGO COUNTY CMS PROGRAM

REQUEST FOR FORMULARY CHANGE FORM

Fax Completed Form to (858) 565-4091

Attention: Medical Management Services, Manager

DATE FORM COMPLETED: ____________________

REQUESTED BY: ____

CLINIC __________________________________ SPECIALTY ____

PHONE NUMBER: _________________ FAX NUMBER: ________________ EMAIL: _____________________

COMPARABLE DRUG(S) ON FORMULARY:

1) ____

2) ____

DRUG INFORMATION

GENERIC NAME _________________________ BRAND NAME ____

MANUFACTURER __________________________ DOSAGE: ____

MEDICAL INDICATIONS: ____

____

PRECAUTIONS/ALERTS: ____

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ADVANTAGES AND DISADVANTAGES: (YOU MAY ATTACH REFERENCES OR PUBLICATIONS THAT SUPPORT THE EFFICACY OF THIS DRUG) ____

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FOR CMS PROGRAM USE ONLY

COMMITTEE COMMENTS: ____

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DRUG COST PER MONTH_________________________ POTENTIAL OVERALL COST ___________________________

ADVANTAGE/DISADVANTAGE ____

ACCEPTED: ______________ REJECTED: ________________ DATE: ______________________________

DATE ADDED TO FORMULARY ________________________________ FORM 10/01/08