



INLAND EMPIRE HEALTH PLAN

**REQUEST FOR ADDITION OR DELETION
OF A DRUG TO THE FORMULARY**

GENERIC NAME: _____ **BRAND NAME:** _____

MANUFACTURER(S): _____

DOSAGE FORM: _____

Pharmacological Classification: _____

Indications: _____

What similar drugs are currently available? _____

What therapeutic advantage(s) does this drug have over the standard drug therapy? _____

In how many patients do you expect this drug to be used during the next six months? _____

What drug(s) currently used for this/these indications(s) may be deleted if this product is added to the formulary?

Should use of this drug be restricted to certain physicians or institutions because of the potential for misuse, high cost, or toxicity? _____

REQUESTER'S NAME: _____

ADDRESS & TELEPHONE: _____

SIGNATURE OF REQUESTER: _____ **DATE:** _____