DHS COMMUNITY PARTNERS
PRIMARY CARE FORMULARY ADDITION/REVISION REQUEST

DATE

INSTRUCTIONS
1. REQUEST MUST BE TYPED OR HAND WRITTEN.
2. FILL OUT COMPLETELY INCLUDING REQUIRED SIGNATURES.
3. ATTACH SUPPORTING SCIENTIFIC REFERENCES AND EVIDENCE.
4. ATTACH COMPLETED CONFLICT OF INTEREST DISCLOSURE SIGNED BY REQUESTING PHYSICIAN.
5. SUBMIT TO DHS PHARMACY AFFAIRS OFFICE VIA **FAX# 310-669-5609** OR VIA **EMAIL: PRIORAUTH@DHS.LACOUNTY.GOV.** REQUEST WILL BE REVIEWED AT A FUTURE PRIMARY CARE PANEL COMMITTEE MEETING.

EVALUATION CRITERIA:
- NEED (RELATIVE TO THE DISEASE STATES AND CONDITIONS OF PATIENTS TREATED)
- EFFECTIVENESS (EFFICACY, PHARMACOKINETIC PROPERTIES, BIOEQUIVALENCE, THERAPEUTIC EQUIVALENCE)
- SAFETY (ADVERSE EFFECTS, MEDICATION SAFETY CONSIDERATIONS)
- FINANCIAL (PHARMACOECONOMIC IMPACT)

REQUESTED DRUG	GENERIC NAME	
	BRAND NAME AND MANUFACTURER	
	DOSAGE FORMS AND STRENGTHS	
TYPE OF REQUEST (PLEASE "X")	☐ ADDITION	☐ RESTRICTION CHANGE
	☐ NEW STRENGTH/DOSAGE FORM	☐ DELETION
DESCRIPTION OF REQUEST (PLEASE "X")	☐ A NEW PRODUCT WITH PHARMACOLOGIC EFFECTS UNLIKE OTHER FORMULARY PRODUCTS	
	☐ AN IMPROVEMENT ON A FORMULARY PRODUCT	NAME OF DRUG
	DELETE FORMULARY DRUG ☐ YES ☐ NO	EXPLAIN BELOW
REASON FOR REQUEST PLEASE INCLUDE PHARMACOLOGICAL EFFECTS AND PROPOSED USE. IF THIS DRUG IS SIMILAR TO A STANDARD ITEM, LIST THE ADVANTAGES OF THE STANDARD ITEM AND ADVANTAGES OF THIS DRUG		
FORMULARY RESTRICTION RECOMMENDATION		

PHYSICIAN'S PRINTED NAME	SERVICE	MAIL LOCATION
PHYSICIAN'S SIGNATURE	TELEPHONE NUMBER	E-MAIL ADDRESS
COMMUNITY PARTNER AGENCY CMO SIGNATURE	TITLE	ESTIMATED MONTHLY CONSUMPTION
FOR PHARMACY AND THERAPEUTICS COMMITTEE USE ☐ APPROVED ☐ NOT APPROVED		DATE

Updated 04/08/2016