SAN DIEGO COUNTY CMS

REQUEST FOR FORMULARY CHANGE FORM

Fax Completed Form to (855) 394-7927

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: ____

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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 02/05/2014