Pharmacy and Therapeutics Committee
Request for Formulary Review

Date	
Requestor's name	
Requestor's Phone/Fax#	
Drug Name (Brand Name)	
Drug Name (Generic Name)	
Dosage Form(s) (If not tablet or capsule)	
Indication(s)	
Is there a similar drug on the Formulary?	Yes____No____If yes, list drug(s) below.
AWP of Drug (30 days supply)	
Please provide supporting documentation for addition of the drug to the Formulary.	
Comments	

Submit all completed forms to:
Joseph Cardinalli, PharmD
Pharmacy Director
Contra Costa Health Plan
595 Center Avenue, Suite 100
Martinez, CA 94553
Fax: 925-313-6412