Request for Formulary Status Reconsideration

Capital

Please complete one form for each medication for which you are requesting reconsideration of formulary status by the Pharmacy and Therapeutics (P&T) Committee.

Note: This form is not to be used for patient-specific requests. Processes for patient-specific requests are described in the Provider Manual.

Requestor information (please print or type clearly)		
Name	Specialty	
Address		
City	State	ZIP Code
Phone number	Fax number	

Medication information	
Drug name	Manufacturer (if known)
Indication(s)	
Advantages of requested drug product over current preferred medications.	
Additional comments (additional documentation and/or references are welcome).	

Signature: _____ Date: ____/____/_____

Mail or fax completed form to:

Pharmacy Services
P.O. Box 773735
Harrisburg, PA 17177-3735
Fax: 717.651.4211

The P&T Committee will review drug-specific requests and communicate the results of the review to the requesting Provider. Pharmacy Services staff will make every effort to include a review of the requested medication at the next quarterly P&T Committee meeting following receipt of a Request for Formulary Status Reconsideration.

Internal use only

Receive date: ____/____/_____

P&T review date: ____/____/_____

P&T recommendation:

☐ Move product to preferred/formulary status.
☐ Do not move product to preferred/formulary status.
☐ Other (see comments).

Requestor notification date: ____/____/_____

Comments: _____

Signature: _____