KAISER PERMANENTE®

<u>Drug Formulary Addition and Deletion Request</u>
Kaiser Foundation Health Plan of Mid-Atlantic States
Formulary Addition/Deletion Request

Instructions:
Use the Addition/Deletion request form to request a review for addition or deletion of a medication to the Kaiser Permanente Mid-Atlantic States drug formulary. The Kaiser Permanente of Mid-Atlantic States (KPMAS) Pharmacy and Therapeutics Committee will consider requests at any time submitted by KPMAS health plan members, Mid-Atlantic Permanente Medical Group and Affiliated providers, and KPMAS pharmacists for the addition or deletion of a medication to the formulary.

To request that a medication be added or deleted from the formulary, please fill out the request form on page 2 of this document. Once completed you may mail the completed form to:

Regional Pharmacy &Therapeutics Committee Co-Chair,
Clinical Pharmacy
4000 Garden City Drive
Hyattsville, MD 20785
Attn: James Chai Wang

or

Send via email to James Chai Wang at james.c1.wang@kp.org

The KPMAS Pharmacy and Therapeutics Committee will evaluate the request. If the committee has made a decision on a drug, a re-review will not be considered for at least six months.

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Kaiser Foundation Health Plan of Mid-Atlantic States
Formulary Addition/Deletion Request

Requestor Name:
_____

Requestor Address: _____

Requestor Phone Number: _____

Is the request from a: (circle one)   Member   Physician   Pharmacist   Other
Healthcare Professional

Is the request for: (circle one)   Addition   or   Deletion

Is the request for: (circle one)   Commercial   or   Medicare Part D formulary*
(*separate formulary drug list for members 65 years of age and over with Medicare Part D
benefits)

The medication for which a change is being requested:

1. Generic Name of the Drug: _____

2. Brand Name of the Drug _____

3. Drug strength(s): _____

4. Dosage Forms: _____

5. Is this request for a specific brand name? _____ Yes_____ No
   Identify brand name: _____

6. Reason for the formulary change request:
_____
_____
_____
_____

7. Please list any studies that support the addition/deletion of this agent to/from the current
formulary (use back of form or additional pages if necessary)
_____
_____
_____
_____

Signature:_____ Date: _____