KAISER PERMANENTE®

Drug Formulary Addition and Deletion Request
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 forward the completed form to:

Regional Pharmacy &Therapeutics Committee Co-Chair,
Springfield Medical Office Building
Clinical Pharmacy, 5th Floor
6501 Loisdale Road,
Springfield, VA 22150
Attn: Kimberly Grant

or

Fax at 703-922-1280
Attn: Kimberly Grant
Drug Review Request

You will receive confirmation from a Kaiser Permanente Pharmacy representative within 14 business days of receipt of the request. 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. You will be notified from the chairperson or designee within 14 business days of the P&T Committee decision.

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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: _____