



1700 Bent Creek Blvd.  
 Suite 200  
 Mechanicsburg, PA 17050

**Suggestion and Comment Form for Pharmacy & Therapeutics (P&T) for Community Health Choices**

Date of Request	Email Address
Name	Phone Number
Specialty	Fax Number
Mailing Address	Member, Physician, Pharmacist or other (circle one)

Potential Conflict of Interest:

- Yes No      Have you received research support or financial support from the manufacturer of requested agent?
- Yes No      Do you have a consultant agreement with the manufacturer of requested agent?
- Yes No      I, my spouse, or my dependent have a financial interest in the manufacturer of requested agent?

Is there a topic you would like to have covered by P&T (e.g. specific drug/drug class)?

Requested Drug/Device Information:

Action: Add to formulary      Remove from formulary      Modify      (circle one)	
Drug/Device (Brand or Generic):	
Dosage form:	Strength:
FDA-approved indication:	
Other indications for use or being studied:	
Are there similar drugs on the Statewide PDL or supplemental formulary: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, name of similar drug(s):	

Rational for Requested Drug/Device:

List therapeutic advantages/disadvantages of requested drug over formulary drugs to treat the same condition:



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Is this drug more/less toxic than other formulary drugs? List any safety issues (side effects or precautions)

What is the frequency this drug would be used by your practice?

Is this drug more/less cost effective in lowering healthcare costs?

Any additional rationale for recommendation:

Supporting documentation: Please cite or attached peer-reviewed literature in support to above answers.

Signature:	Date:
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Please fax filled out form to 844-348-6546.

You will receive a response from the pharmacy team after the next P&T committee meeting or if there are any questions about your request.

Thank you for your suggestion,

PA Health & Wellness Pharmacy Department