

**Pharmacy Services: Addition to
Formulary Request Form**



Please print clearly.

Prescriber's Name: _____

Specialty: _____ Phone: _____

Address: _____

State brand/generic names, dosage, strength and manufacturer of the drug you are suggesting for formulary addition, if known:

What formulary agents, if any, are available in the same therapeutic class, or for the same indication? Please list.

Indicate the advantage of the recommended agent over those current formulary alternatives. Note: Submit supporting literature citations with request. A minimum of two documenting journal articles are requested.

Are you affiliated with this drug's manufacturer? If yes, how?

PRESCRIBER SIGNATURE _____	DATE _____
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**Please submit completed form to ConnectiCare, Pharmacy Services, Attn: Clinical Department,
55 Water Street, New York, NY 10041.
Or, fax to ConnectiCare Clinical Pharmacy Services at 1-877-300-9695.**