



PARTNERSHIP HEALTHPLAN OF CALIFORNIA
 4665 Business Center Drive
 Fairfield, CA 94534
 (707) 863-4414
 FAX (707) 863-4330

ATTACHMENT A

PROVIDER FORMULARY ADDITION/CHANGE REQUEST FORM

Drug Name	
Dosage Forms and Strengths	
FDA Approved Indications	
Rationale for Request (superior efficacy/safety profile, unique indications, comparative cost-effectiveness): *Please also attach any relevant articles supporting this request*	
Requested By (print)	
Phone Fax Email	
Please include or attach any supporting documents and send to: <div style="text-align: center;"> <p>PHC Pharmacy Director 4665 Business Center Drive Fairfield, CA 94534 FAX: (707) 863-4330 Email: PHCFormulary@partnershiphp.org</p> </div>	
Signature X	Date

To be considered for review all sections of form must be completed & form must be received by PHC 30 days prior to the quarterly Pharmacy & Therapeutics (P&T) Committee meeting.