An Independent Licensee of the Blue Cross and Blue Shield Association

Requesting Physician: Please complete this form with supporting documents and mail or fax to HMSA-Pharmacy Management, 1601 Kapiolani Blvd. Suite 1000., 10-KB-PM, Honolulu, HI 96814. Fax: 808-948-8282. Please email questions to HMSAPharmacists@hmsa.com. Incomplete applications will be returned to the requestor.

APPLICATION FOR FORMULARY REVIEW

1. **Generic Name:** _____ **Brand Name**: _____
2. **Dosage Form(s) and Strength(s):** _____
3. **Indication(s) and Usage, include FDA and non-FDA approved indications**:

   _____

   _____

   _____
4. **What do you believe are the relevant factors in requesting this drug as opposed to using currently available drugs on the formulary? (Check all that apply)**

   ☐ The drug is FDA approved for the proposed indication where others are not
   ☐ The drug is more clinically efficacious
   ☐ The drug has an improved side effect profile
   ☐ The drug is more cost effective
   ☐ Other: _____

   _____

   _____
5. **Comparable drugs on the HMSA formulary:** _____
6. **Current formulary drugs which may be deleted at the addition of the requested drug:**

   _____
7. **List or attach at least two applicable clinical studies to substantiate the request of this drug:**

   _____

   _____

   _____

   _____
8. **Conflict of interest disclosure**

   Has the requestor received any honoraria or research funding from the company manufacturing, marketing or distributing this drug?

   ☐ Yes ☐ No

Requestor Name (Print): _____ Signature: _____

Mailing Address: _____ Phone: _____

_____ _____

_____

PHARMACY & THERAPEUTICS ADVISORY COMMITTEE USE ONLY

Date Received:_____ ☐ Approved ☐ Not Approved ☐ Deferred

Comments: _____

_____

P&T Chairperson Signature:_____ Date: _____