HEALTHPARTNERS PHARMACY SERVICES
REQUEST FOR ADDITION OF DRUG TO HEALTHPARTNERS FORMULARY

Fax to: 952-853-8700 or 1-888-883-5434 (toll free)

DRUG REQUESTED _____

1. For what type of patients will this drug be used? *(Please indicate subsets of patients if appropriate)*
   _____
   _____

2. What formulary drug(s) are currently being used for these patients?
   _____
   _____

3. What therapeutic advantage(s) does this drug have over the currently available formulary drug therapy?_____
   _____

4. For how many patients would you personally prescribe this drug during the next six months? _____

5. In what percentage of the patients who currently receive or would be candidates for a formulary drug therapy will this drug be prescribed _____

6. What drug(s) currently used for this (these) indications can be deleted if this product is added to The formulary? _____
   _____

7. Should use of this drug be restricted to certain physicians or services or disease states because of the potential for misuse, high cost or toxicity? Yes No *(if YES explain)* _____
   _____

8. Have you used this drug previously as part of any research study? Yes No

9. Have you been supported either directly or indirectly by the supplier(s) of this drug? Yes No

10. Do you have any potential conflicts of interest with respect to this drug? Yes No

11. List relevant references from the biomedical literature to support this request:
    _____
    _____
    _____
    _____

_____ _____ _____
Signature of Requestor Date Clinic/Address

*** THIS FORM MAY BE PHOTOCOPIED ***

11/27/19