Pharmacy Committee
REQUEST FOR DRUG LIST REVIEW

Date Of Request:____ /____ /________

Requestor's Name:____

Requestor's Specialty:____

Requestor's Phone Number: (   )_______ - _____________

Requestor's Fax Number: (   )_______ - _____________

Drug Name (Brand):____

Drug Name(Generic) :____

Strength(s) :____

Dosage Form :____

Indications:____

____

____

____

Is there a similar drug or drugs on the drug list? ❑ Yes ❑ No

If yes, please list:____

____

____

Average Wholesale Price (AWP) of Requested Drug (30-day supply)_______________

PLEASE PROVIDE DOCUMENTATION TO SUPPORT THE FOR ADDITION OF THE REQUESTED DRUG TO THE DRUG LIST(may attach additional documents)

Submit Completed Form to:
Passport Health Plan
Pharmacy Department
305 W. Broadway
Louisville, KY 40202
or fax to 502-585-7998

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