Preferred Drug List (PDL) Change Request

Note: Complete this form in full. Incomplete forms will not be presented to the Pharmacy and Therapeutics Committee.

Brand Names(s):_____Generic Name:_____

Dosage Form(s):_____Dosage Strength(s):_____

Therapeutic Application(s):_____

_____

Reasons for Addition to the PDL: _____

_____

_____

Documented advantages of current preferred Drug List products (list studies):
Note: References from sources that are considered free of drug company influence are given highest consideration. References from journal supplements will generally not be considered.

1. _____

2. _____

3. _____

4. _____

Preferred Drug(s) this product will replace on the PDL:_____

Disclaimer:
Please list all drug companies with whom you have had a financial relationship, either directly or indirectly, during the last 5 years. This includes but is not limited to speaker's fees, speaker training, consultancies, grants and awards, "free" drug trials, research money or quid pro quo items such as computers or electronics, trips and recurring meals or sponsorships. This does not include stock ownership. You may attach additional pages for complete disclosure.

1.
2.
3.
4.
5.

Physician Name (Print):_____

Signature:_____Date:_____

Address: _____

Phone: (___)_____Fax: (___)_____

Please complete and return to:

MHS Pharmacy Department, 550 N. Meridian Street, Suite 101, Indianapolis IN, 46204

Fax: 1-844-487-5306