

### **Approved Drug List Addition Request Form**

1. Generic Name:
2. Proprietary Names(s) and Manufacturers:
3. Dosage Forms and Strengths:
4. Pharmacologic Class (unique entity?):
5. FDA approved indication(s):
  
6. Other indications for which this agent is being used and/or studied:  
  
Describe the role of this agent in the management of these indications:
  
7. Comparable agents on the CalOptima Approved Drug List:
  
8. Reasons why this agent is superior to agents currently on the CalOptima Approved Drug List:
  - a. Is it more efficacious than other available therapies?
  - b. Is it more/less toxic than other available therapies?
  
9. Which agents may be deleted from the CalOptima Approved Drug List if this medication were added?
  
10. Special cautions or side effects:
  
11. Pharmacoeconomics:
  - a. Is it more/less costly than other medications used for the same indications?
  - b. Is it more/less cost-effective in lowering overall health care costs?
  
13. Anticipated number of CalOptima patients who will be treated annually with this agent:
14. Please provide a related bibliography and copies of two pivotal studies from peer-reviewed literature that demonstrate superiority of this agent over others. Randomized controlled trials comparing this drug to other drugs used to treat the same disease state are preferred.

## Statement of Economic Interest

Requests for addition of a medication to the CalOptima Approved Drug List are subject to CalOptima's Conflict of Interest policies. Therefore, CalOptima Providers who initiate requests for addition of a drug to the CalOptima Approved Drug List are required to disclose whether or not they have any financial interest or other relationships with the pharmaceutical company manufacturing the requested medication.

This form is designed to enable the Pharmacy and Therapeutics Committee to be aware of any financial interests when it considers Approved Drug List addition requests; it does not preclude CalOptima Providers with such interests from making addition requests and will not preclude approval of the requested drug for addition to the Approved Drug List.

In the past 24 months, have you or your practice site received research funds or other financial support from the manufacturer of this drug?

\_\_\_\_\_ Yes \_\_\_\_\_ No

In the past 12 months, have you received any form of loan, gift, salary, honoraria or compensation for consulting services from the manufacturer? Have you maintained any other financial interest (e.g. stock options) in the drug's manufacturer?

\_\_\_\_\_ No

\_\_\_\_\_ Yes      Amount: \_\_\_\_ less than \$1,000    \_\_\_\_ \$1,001-\$10,000    \_\_\_\_ over \$10,000

If you answered yes to either of the above questions, please indicate the nature of such financial support:

|                       |
|-----------------------|
| Requestor Information |
|-----------------------|

Requested by (please print):

Mailing Address:

Phone (    )      Fax (    )      e-mail address: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Printed)

**Please fax completed form to CalOptima at (714) 481-6459**