RYAN WHITE PROGRAM
PRESCRIPTION DRUG FORMULARY REVIEW REQUEST

FOR OMB-GC USE ONLY

Date of Request: _____

Request for: ____ Addition ____ Deletion

_____ Date Received
_____ Date of First PUPAP Review
_____ Date of Approval
_____ HRSA Drug Code

(1) Generic/Proprietary name of drug product:

_____

(2) Specific formulation(s) considered:

_____

(3) Specific indications for use:

_____
_____

(4) Please list other products currently in the formulary which are considered similar to the proposed addition/deletion:

_____
_____

(5) Should there be any restrictions on the use of this product?

_____
_____

(6) Please summarize your reasons and justification for this request. Provide appropriate references where applicable.

_____
_____
_____

(7) I understand that this request will be considered at the next meeting of the Pharmaceutical Utilization Physicians Advisory Panel (PUPAP) or the Medical Care Subcommittee.

_____
(Attending practitioner's signature)

Print Name: _____
Phone/Pager: _____
Clinic Site: _____

Please forward this request to:

Carla Valle-Schwenk, Program Administrator
Miami-Dade County Office of Management and Budget
Grants Coordination/Ryan White Program
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Miami, Florida 33128
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