



**ATTACHMENT A
REQUEST FOR ADDITION TO MAP FORMULARY**

TO BE COMPLETED BY PROVIDER:

1. Request Date: _____
2. Name of Requesting Provider: _____
3. Contact: Telephone _____ Email: _____
4. Drug Trade & Generic Name : _____
5. Strength(s) and dosage form(s) (e.g. tablets, liquid, etc.): _____
6. Conditions to be treated or intended use: _____

7. Current formulary medications available to treat above conditions? _____

8. Advantage of requested product over currently available formulary product(s). Please submit any literature supporting this with submission:

9. Please list any conflicts of interests, financial or otherwise, you have with this request?

Date reviewed: _____

P&T approval: Y / N