# REQUEST TO CHANGE STATE HIV MEDICATION FORMULARY

1) Request to (check one): ☐ ADD medication to formulary ☐ DELETE medication from formulary

2) Brand name of medication:  
3) Generic name of medication:

4) Will this medication replace the use of another presently on the formulary (check one): ☐ NO ☐ YES
Which medication(s)?

5) Name of pharmaceutical supply company (if single source):

6) Medical criteria for using this medication:

7) Other medications on the formulary that must be used in conjunction with this medication (multi-drug therapy):

## MONTHLY CALCULATIONS

8) How is the medication supplied:  
9) Maximum program supplied units per client:

10) Cost per unit supplied:  
11) Estimated number of clients that will use this medication:

## FISCAL IMPACT

12) Present monthly expenditures:  
13) Estimated monthly expenditure for this medication:

14) Estimated monthly medication expenditures with the (check one) ☐ ADDITION or ☐ DELETION of this medication:

15) Maximum monthly expenditures to stay within the current budget:

## ADVISORY COMMITTEE RECOMMENDATION

The Committee (check one) ☐ recommends / ☐ does not recommend the ☐ ADDITION / ☐ DELETION of this medication.

☐ This request is Bureau generated and was not presented to the Committee.

## COMMISSIONER OF HEALTH APPROVAL

Request to (check one) ☐ ADD / ☐ DELETE this medication is ☐ APPROVED / ☐ DENIED.

Signature of the Commissioner of Health:  
Date: