

State of Alaska Department of Health and Social Services, Division of Health Care Services
Submission Request Form for Pharmaceutical Manufacturers

E-mail as an attachment to patelu@magellanhealth.com and EAEdwards@magellanhealth.com; include in subject line **Manufacturer Submission**

OR Fax this request to: 1-888-656-6822 ATTN: Umang Patel, PharmD and Elaine Edwards, RPh

(Note: Processing May be Delayed if Information Submitted is Illegible or Incomplete)

Members of the Pharmacy and Therapeutics (P&T) Committee have requested that all clinical information, questions, or comments about the Preferred Drug List (PDL) be sent directly to Magellan Medicaid Administration. Manufacturers and other interested parties have been requested not to contact the members directly. Written comments on the PDL from all interested parties should be submitted to Erin Narus, PharmD, R.Ph. at the State of Alaska.

Note: Manufacturers submitting comments are requested to do so through their Product Manager using this form. This form constitutes a request for **NEW** information pertaining to peer-reviewed literature including off-label peer-reviewed studies.

Contact Information

MANUFACTURER NAME: <input style="width: 95%;" type="text"/>	DATE: <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 10px; text-align: center;">-</td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 10px; text-align: center;">-</td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>			-			-				
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PRODUCT MANAGER'S NAME: <input style="width: 95%;" type="text"/>	TITLE: <input style="width: 95%;" type="text"/>
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ADDRESS:

CITY: <input style="width: 95%;" type="text"/>	STATE: <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>			ZIP CODE: <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>						

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PRODUCT:

Clinical Rationale Request for Consideration (If additional space is required, use Clinical Rationale Continuation Page).

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Published Citations (If additional space is required, use Published Citations Continuation Page).

MAGELLAN MEDICAID ADMINISTRATION USE ONLY – DO NOT MARK IN THIS AREA

ACTION TO BE TAKEN:

DATE:

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