



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



Directions for submitting completed form: E-mail as an attachment to Umang Patel, PharmD (patelu@magellanhealth.com) and Ryan Ruggles, PharmD (rugglesr@magellanhealth.com); include in subject line: **Manufacturer Submission**.

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 Matt Parrott, 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: _____

Date: _____

Product Manager First Name: _____

Product Manager Last Name: _____

Product Manager Title: _____

Email Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Product Manager Phone: _____ Product Manager Fax: _____

Product: _____

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (Via return FAX) immediately and arrange for the return or destruction of these documents.

Product Manager's Name (Last, First): _____

CLINICAL RATIONALE REQUEST FOR CONSIDERATION

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

Product Manager's Name (Last, First): _____

CLINICAL RATIONALE REQUEST FOR CONSIDERATION (*CONTINUED*)

Product Manager's Name (Last, First): _____

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: _____

Product Manager's Name (Last, First): _____

PUBLISHED CITATIONS (*CONTINUED*)
