BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Health Choice

BCBSAZ Health Choice

FORMULARY ADDITION REQUEST FORM

Pharmacy and Therapeutics Committee

TO BE COMPLETED BY THE REQUESTING PROVIDER:

- ☐ **Health Choice Arizona (AHCCCS) Formulary Addition**
- ☐ **Health Choice Pathway Medicare Formulary Addition**

Request Date: _____

Brand Name: _____ Generic Name: _____

Projected number of patients on drug per month, year, etc.: _____

Dosage forms (tablets, suppositories, topical cream, etc.) requested: _____

_____

Please provide clinical justification for adding this drug to the formulary? _____

_____

_____

Which formulary drug(s) can this product replace? _____

_____

Please declare **potential "conflict of interest"** ___ exists or ____ does not exists with the requesting provider regarding this drug request; e.g. stock owned in drug manufacturer, paid presenter or researcher for drug company, etc.

If conflict of interest exists, please explain: _____

_____

Requesting Provider Name: _____ Signature _____

Please submit at least two (2) clinical articles that support the addition of this drug to the formulary. Do not send promotional materials

Send to:
Office of the Medical Director
BCBSAZ Health Choice Pharmacy
8220 N. 23rd Ave.
Phoenix, AZ 85021

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To be completed by BCBSAZ Health Choice Clinical Pharmacist:

Pharmaceutical Manufacturer: _____

Pharmacologic Category:_____ Project use per month:_____

FDA approved Indications:_____

_____

Summary of efficacy/value compared to current formulary options:

Attach clinical documentation for the requested drug. Information should include but is not limited to drug pharmacology, adverse effects, contraindications, etc.

Date Reviewed by P&T Committee: _____

P&T Committee Decision:

____ Do Not Add
____ Add without Utilization Management (UM)
____ Add with UM. Prior Authorization, Step Therapy, Quantity Limit: _____

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