BlueCross BlueShield Arizona

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Health Choice

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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:______________________

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

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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, Health Choice
Pharmacy 410 North 44th Street, Suite 900
Phoenix, AZ 85008

To be completed by 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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