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 Generations 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, 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: _______________________________
________________________________________________________________________________________