



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 exist 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



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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: _____
