



**Health Choice Generations
FORMULARY ADDITION REQUEST FORM
Pharmacy and Therapeutics Committee**

TO BE COMPLETED BY THE REQUESTING PROVIDER:

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



To be completed by Health Choice Generations 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 Submitted to P&T Committee: _____

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: _____
