BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association | Health Choice

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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