NON-FORMULARY MEDICATION REQUEST FORM

Patient Name_____ MPI #_____ Unit_____

Division ____ASD ____GPD ____WFD

Prescriber_____ Fax #_____ Date_____

Non-formulary medication requested
(Include dosage regimen)_____

Indication for non-formulary medication_____

What are the available formulary alternatives? _____

What is the clinical justification for obtaining the non-formulary medication?
Determination criteria include patient intolerance to formulary medication, allergy status, documented previous treatment failure to formulary medication, and documentation of superior clinical effect of the non-formulary medication.

_____
_____
_____
_____
_____
_____
_____
_____

Was this medication recommended by an outside consultant? _____

FOR OFFICIAL USE ONLY

Criteria Met _____ Date_____
(signature/name of Medical Director)

Follow up needed _____ Date_____

Please fax signed form to the unit and to
CVH Pharmacy at X6159 or
Blue Hills Pharmacy at 860-293-6454