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