NON-FORMULARY DRUG REQUEST

Must be completed by the requesting prescriber for Pharmacy

Please check the appropriate box and complete the following:

□ Individual Patient Request (patient specific account #_______________________)

□ Addition of Drug to Formulay (P&T Committee for approval)

Drug Name: _______________________________________________________________________________

Strength / Dose / Form: _____________________________________________________________________

Dosing Interval: ____________________________________________________________________________

Indication: ________________________________________________________________________________

Criteria for selecting this drug as opposed to drug currently on formulary:
_________________________________________________________________________________________

What comparable Drug, if any, may be deleted, if necessary upon inclusion of this drug to the formulary:
_________________________________________________________________________________________

List your conflicts of interest:
_________________________________________________________________________________________

Projected Annual Usage: ____________________________  J-Code (1206d clinic/CVIP):
_________________________________________________________________________________________

Ordering Physician

Name of Requesting Physician: ________________________________________________________________

Specialty: __________________________________________________________________________________

Date of Request: ____________________________________________________________________________

Signature: __________________________________________________________________________________

(attach relevant references/literature support)

Upon completion, please submit form to Pharmacy. Thank you.