REQUEST TO USE NON-FORMULATORY DRUG

PROVIDERS: This form should be completed when it appears clinically necessary to prescribe a drug that is not included in the Department of Corrections Formulary. PLEASE PRINT. Use additional sheets if necessary.

Patient’s Name: ____________________________ ACOMS #: __________

Admit Date: ____________________________ Discharge Date: ____________________________

GENERIC NAME(S): ____________________________

PROPRIETARY NAME(S): ____________________________

Prescribed dosage: ____________________________

Anticipated length of treatment: ____________________________

Diagnoses: ____________________________

Allergies: ____________________________

Comparable drugs in formulary: ____________________________

Reason(s) why comparable drugs in formulary, if applicable, will not suffice: ____________________________

Other medications used by patient: ____________________________

Institution: ____________________________ Date: __________

Requested by: ____________________________

Action by Pharmacist:

___ Prescription filled
___ Returned to prescriber today for completion of form
___ Referred to Clinical Director or Designee

Comments:

Signature of Pharmacist: ____________________________ Date: __________

Action by Clinical Director or Designee (if referred)

___ approved non-formulary request
___ disapproved non-formulary request (notify prescriber today to choose a medication on the formulary)

Comments:

Signature of Clinical Director or Designee: ____________________________ Date: __________