NON-FORMULARY DRUG APPROVAL FORM

Required for review with 2nd physician or P+T Committee Representative knowledgeable regarding medication if:

Cost below $500 per day or $3000 per treatment, no agreement between attending physician and pharmacist

Cost above $500 per day or $3000 per treatment

Send completed form to the Pharmacy Site Manager/ Lead and attach to medication order in pharmacy information system

Site: ____________________

Ward/Department: ____________________

PATIENT INFORMATION LABEL / ADDRESSOGRAPH
Name:
Medical Record Number:
Birth date:
PHIN#

Drug Requested	Dosing, Schedule & Expected Duration of Therapy

Previous Therapies Used (brief summary)

Rationale for Therapy (e.g. versus alternatives)

Reference(s) to Support Request (if available)

Estimated Total Inpatient Cost $__________ OR **Estimated Daily Inpatient Cost** $__________

Attending Physician's Name: ____________________ (Print Name)

Phone #: ____________________

Completed by/reviewed by pharmacist: ____________________ (Print Name) **Date:** __________

Recommended by specialist or Reviewed by 2nd local Physician or P+T Committee Representative: ____________________ (Print Name) **Date:** __________

Comments: ____________________

☐ **Proceed as submitted** ☐ **Proceed with the following conditions**: ____________________