



SUNY  
**DOWNSTATE**  
Medical Center

PHARMACY DEPARTMENT  
UNIVERSITY HOSPITAL  
AT 445 LENOX ROAD

**NON-FORMULARY DRUG REQUEST FORM**

The policies of the Medical Staff's Pharmacy and Therapeutics Committee require that this form be completed **in full (including appropriate signatures)** before a non-formulary drug can be purchased and dispensed by the Pharmacy Department. Because it will be necessary to obtain the non-formulary drug from outside the hospital, there may be at least a 24-hour delay in obtaining such drugs. Therefore, an equivalent formulary drug should be considered and used whenever possible. All non-formulary requests are reviewed by the Pharmacy and Therapeutics Committee.

**ALL REQUESTS MUST BE ACCOMPANIED BY A WRITTEN DOCTOR'S ORDER**

PATIENT NAME: \_\_\_\_\_

PATIENT MEDICAL RECORD NUMBER: \_\_\_\_\_

PATIENT LOCATION: \_\_\_\_\_

DRUG NAME, DURATION, DOSAGE FORM: \_\_\_\_\_

**SPECIFIC THERAPEUTIC REASONS WHY THIS AGENT IS NECESSARY OVER FORMULARY DRUGS OF SIMILAR PHARMACOLOGIC ACTION:**

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I have been informed by (Pharmacist's name): \_\_\_\_\_, RPh., of possible formulary options to my non-formulary request and have determined that my non-formulary request is medically necessary for my patient. I am also aware of the possible delay in obtaining my non-formulary request.

Date: \_\_\_\_\_

Signature of Prescribing Physician: \_\_\_\_\_

Signature of Attending Physician or Chief Resident: \_\_\_\_\_

Print Name: \_\_\_\_\_

Service: \_\_\_\_\_

Phone/Beeper #: \_\_\_\_\_

Signature of Director of Pharmacy: \_\_\_\_\_

Revised 12/01