OKLAHOMA DEPARTMENT OF CORRECTIONS

NON-FORMULARY MEDICATION REQUEST FORM

(This form must be legibly completed in its entirety)

Cost Center #:_____ Name of Facility: _____

Date Requested: ____/____/____ Return Fax #:_____

Inmate Name: _____ ODOC #: _____

☐ Initial Treatment ☐ Renewal

Medication Requested: _____ Strength:_____ Duration:_____

Medical Condition Being Treated:_____

Directions:_____ Prescriber:_____

Formulary Medications Previously Tried:_____

Reason non-formulary medication is necessary (check all that apply):

- ☐ Inmate is allergic/intolerant to medication on formulary
- ☐ Formulary medications have been tried and were ineffective
- ☐ Inmate has significant medical problem unresponsive to formulary medication
- ☐ No comparable medication on formulary
- ☐ Other – Explain:_____

_____

_____

PA/NP Signature (followed by legible initials):_____ Date:_____

Physician Signature (followed by legible initials):_____ Date:_____

Comments: Contract Pharmacy Services ☐ Approved as Requested ☐ Approved with Modifications ☐ Denied Explanation: _____ _____ _____ Name: _____ Signature: _____ Date: _____	Comments: P & T Committee Chairman/ Chief Psychiatrist: ☐ Approved as Requested ☐ Approved with Modifications ☐ Denied Explanation: _____ _____ _____ Name: _____ Signature: _____ Date: _____	Comments: Chief Medical Officer, Office of Medical Services: ☐ Approved as Requested ☐ Approved with Modifications ☐ Denied Explanation: _____ _____ _____ Name: _____ Signature: _____ Date: _____

IMPORTANT: THIS DOCUMENT MUST BE MAINTAINED ON FILE BY THE CHSA FOR FIVE YEARS.

Instructions:
Fax request to contract pharmacy for approval/denial **(1-866-307-9748)**