Oklahoma Board of Nursing 2501 N. Lincoln Blvd., Ste. 207 Oklahoma City, OK 73105 405-962-1800

Formulary Advisory Council Procedure for Amending the Formulary

The following is a procedure for submission of requests for revision to the Exclusionary and Inclusionary Formularies to the Formulary Advisory Council for review and consideration.

- I. Individuals requesting a revision to the Inclusionary or Exclusionary Formulary must submit a completed written request to the Oklahoma Board of Nursing ("Board") office on a form approved by the Board. The request will include the rationale for the request, the individual's position, literature to support the position, and information on the drug from the drug manufacturer.
 - Such information must be received in the Board office at least 30 calendar days prior to the scheduled Formulary Advisory Council Meeting, to allow all Formulary Advisory Council members to review the information prior to the Formulary Advisory Council meeting.
- II. Recommendations for revision of the Inclusionary Formulary and Exclusionary Formulary approved by the Formulary Advisory Council will be considered by the Board during the next regularly scheduled meeting of the Board in accordance with 59 O.S. §567.4a.9. a. and d. and 59 O.S. §567.4b.A. and C.
- III. The Formulary Advisory Council, during a scheduled annual meeting and in the course of review and discussion of the current Inclusionary and Exclusionary Formularies, may recommend revisions to the Formularies to the Board, without following this procedure, if Council Members are in agreement of the recommendation and a member of the Formulary Advisory Council does not request review of additional information concerning the revision.

IV. Regulatory Authority

59 O.S. §§567.4a. 9. a. and d., and 567.4.b. A. and C.

Board Approved: 11/20/97

OBN Policy/Guideline #P-50

Board Reviewed w/o Revision: 07/25/01; 9/27/11; 9/29/15; 9/20/16; 9/26/17; 9/25/18; 5/21/19; 11/10/20; 9/21/21 Board Revised: 7/27/04; 9/27/05; 9/23/08; 11/17/14; 11/9/22 Page 1 of

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Formulary

REQUEST TO AMEND THE FORMULARY

Individual Making Request:

1.	NAME					
2.	ADDRESS					
		reet	City	State	Zip Code	
3.	()	()	,		1	
	Area Code/ <i>Home Phone</i> #	Area Code/	Cell Phone # E-Ma	ail Address		
4.	TITLE					
	(CNP, CNM, CNS, CRNA, MD, DO, Pharmacist, Other- specify)					
I am	requesting a change to the fo	ollowing form	ulary:			
4.	Exclusionary Formul	lary (Formular	ry Advisory Council) A	APRNs, CN	Ms, CNSs	
5.	Inclusionary Formulary (CRNA Formulary Advisory Council) CRNAs					
6.	Name of Drug(s):					
7.	Drug Classification and AHFS Reference Number(s):					
	se contact the Associate Director ification//Reference Numbers)	for Nursing I	Practice at 405/962-1800	for assistan	nce with AHFS	
8.	Delete from Formulary					
	Add to Formulary					
	Add precaution and/or restriction					
9.	Rationale for request to amend formulary:					
Plea	se attach the following inform	nation:				
1.	Literature to support your po	sition				
2.	Drug Manufacturer's Inform	nation				
SUB	MIT ALL INFORMATION		ciate Director for Nurs	_	e	
			Oklahoma Board of Nursing			
			Box 52926			
			homa City, Oklahoma			
		Phon	ne - (405) 962-1800	FAX - (40	5) 962-1821	

Information must be received in the Board office at least 30 calendar days prior to a meeting of the Formulary Advisory Council.

Board Approved: 11/20/97

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