

## CMSP Formulary Exception Request Form

Please provide the information below: request will NOT be considered unless ALL sections are complete.

The following criteria are used in reviewing non-formulary medication requests (**CHECK APPROPRIATE BOX**)

- The use of formulary drug is contraindicated for the patient (*allergy/adverse reaction to formulary drug*).
- The patient failed an appropriate trial of the formulary drug alternatives or related agents.
- The choices available on the CMSP drug formulary are not suitable for this patient due to specific medical condition and/or drug is required for optimal medication safety and therapeutic efficacy.
- The use of a formulary drug may provoke an underlying medical condition, which would be detrimental to patient safety.

<b><u>Patient Name:</u></b>	<b><u>CMHC Name &amp; Region Number:</u></b>
<b><u>Patient Address:</u></b>	<b><u>Physician Name/Specialty:</u></b>
<b><u>Patient DOB:</u></b>	<b><u>Physician ID#/DEA#:</u></b>
<b><u>Pharmacy Name &amp; Address:</u></b>	<b><u>Physician Area Code &amp; Telephone Number &amp; Fax Number:</u></b>
<b><u>Diagnosis:</u></b>	<b><u>Physician Address:</u></b>
<b><u>Drug Requested:</u></b>	<b><u>Quantity (per month):</u></b>
<b><u>Dose:</u></b>	<b><u>Length of Treatment (please be specific):</u></b>
<b><u>Strength:</u></b>	<b><u>Dosage Form (e.g. Oral Injection):</u></b>
<b><u>Reason for Medication Request (please be specific, give details):</u></b>	
<b><u>Other Medications Tried and/or Failed (please be specific, give details):</u></b>	
<b><u>Other Pertinent Medical History (relative or pertaining to this request):</u></b>	
<b>Physician's Signature:</b>	
<b>Date:</b>	
<b><u>FOR INTERNAL USE ONLY</u></b>	
<input type="checkbox"/> Approved <input type="checkbox"/> Denied Name: Date:	