STATE OF ALASKA **DEPARTMENT OF CORRECTIONS**

REQUEST TO USE NON-FORMULARY DRUG

PROVIDERS: This form should be completed when it appears clinically necessary to prescribe a drug that is not included in the Department of Corrections Formulary. PLEASE PRINT. Use additional sheets if necessary.

Patient's Name: _____ACOMS #_____

Admit Date: _____ Discharge Date: _____

GENERIC NAME(S): _____

PROPRIETARY NAME(S)_____

Prescribed dosage: _____

Anticipated length of treatment: _____

Diagnoses: _____

_____

Allergies:_____

Comparable drugs in formulary: _____

_____

Reason(s) why comparable drugs in formulary, if applicable, will not suffice: _____

_____

_____

Other medications used by patient: _____

Institution: _____ Date: _____

Requested by: _____

Action by Pharmacist:

___ Prescription filled
___ Returned to prescriber today for completion of form
___ Referred to Clinical Director or Designee

Comments:

Signature of Pharmacist	Date:
Action by Clinical Director or Designee (if referred) ___ approved non-formulary request ___ disapproved non-formulary request (notify prescriber today to choose a medication on the formulary) Comments:	
Signature of Clinical Director or Designee:	Date:

Department of Corrections, Form 807.05E
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