NON-FORMULARY DRUG JUSTIFICATION
FOR SHORT TERM AND LONG TERM TREATMENT
CENTRAL STATE HOSPITAL PHARMACY & THERAPEUTICS COMMITTEE

The composition of the Central State Hospital Drug Formulary is the responsibility of the Central State Hospital Pharmacy and Therapeutics Committee. This form is designed to simplify and justify requests for all drugs and related items which are not normally stocked by the CSH Department of Pharmaceutical Services. Non-formulary drugs are procured from outside the institution, therefore a delay in delivery must be anticipated. It is advisable that the physician, particulary in emergencies, prescribe the appropriate formulary preparation if possible until the non-formulary drug is procured and dispensed to the unit.

RULES GOVERNING REQUESTS FOR NON-FORMULARY ITEMS:

1. Complete this form for the first order of a non-formulary medication.
2. Requesting physician should check the appropriate blocks below:
   - A. Routine (ASAP from wholesaler)
   - B. FOR EMERGENCY USE
   - C. Short term treatment (less than 1 month)
   - D. Long term (1 month or longer)
   - E. Circle the number months desired for treatment lasting 1 month or longer.
3. **Telephone the pharmacist** for CSH Formulary drug alternatives and complete line five.
4. Non-formulary drug requests should be authorized only when there is no alternative drug on the CSH Drug Formulary.
5. Complete line six describing why the formulary item can not be used.
6. Have the Division Clinical Director sign for approval.
7. Fax the form to the pharmacy at the appropriate telephone number 4171(Craig, PSD, FSD units) or 4052 (DDD units). (Kidd Building units should take/send the form directly to the pharmacy on the first floor.)
8. This form is valid for the number of months circled up to a maximum of 12 months.
9. Items deemed emergency by the requesting physician will be procured immediately.
10. The routine use of non-formulary drugs is prohibited.
11. Non-Formulary items previously approved for use by a client at CSH may be continued by the attending physician at the Acute Care Inpatient Hospital at CHD upon admission to that facility.

DATE: ______________________

________ Routine (ASAP from wholesaler) ________ Short Term Treatment (less than 30 days)

________ FOR EMERGENCY USE ________ Long Term Treatment (30 days or more)

1. Non – Formulary drug requested: ______________________________
2. **Long Term Treatment (Circle number of months desired): 1 2 3 4 5 6 7 8 9 10 11 12 MONTHS**
3. Name of patient/client: ______________________________ LU/WARD: ______________________
4. Diagnosis for use of drug requested: ______________________________
   ____
5. CSH Formulary drug alternatives: ______________________________
6. Reason why CSH Formulary drug is not acceptable: ______________________________
   ____

REQUESTING PHYSICIAN: ______________________________ CSH No. _________ Phone: ______________

DIV. CLINICAL DIRECTOR:______________________________ CSH No. _________ Phone: ______________

PHARMACIST: ______________________________