

OKLAHOMA DEPARTMENT OF CORRECTIONS
NON-FORMULARY MEDICATION REQUEST FORM
(This form will be legibly completed in its entirety)

Cost Center #: _____ Name of Facility: _____

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

Inmate Name: _____ DOC #: _____

☐ 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
<input type="checkbox"/> Approved as Requested <input type="checkbox"/> Approved with Modifications <input type="checkbox"/> Denied
Explanation: _____ _____ _____
Name: _____
Signature: _____
Date: _____

Comments: P & T Committee Chairman/ Chief Psychiatrist:
<input type="checkbox"/> Approved as Requested <input type="checkbox"/> Approved with Modifications <input type="checkbox"/> Denied
Explanation: _____ _____ _____
Name: _____
Signature: _____
Date: _____

Comments: Chief Medical Officer, Office of Medical Services:
<input type="checkbox"/> Approved as Requested <input type="checkbox"/> Approved with Modifications <input type="checkbox"/> Denied
Explanation: _____ _____ _____
Name: _____
Signature: _____
Date: _____

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

Instructions:

Fax request to contract pharmacy for approval/denial (1-888-200-7774)

DOC 140130D (R 07/24)