University of Arkansas Pharmacy Advisory Committee Formulary Request

Member Named\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Request\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medication Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for request \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*\_\_\_\_ Individual Review Request : Reason for request must be accompanied by a copy of the member’s chart notes documenting adverse reaction, un-tolerated side effects or member non-response to the preferred medication. If an uncommon side effect is being documented, a completed FDA MedWatch form must also be attached.*

*\_\_\_\_ Plan Design Review : Documentation such as new clinical studies or nationally recognized guidelines must accompany requests for formulary replacement for a perceived clinically superior medication.*

Documentation and completed forms should be sent to :

The UofA Pharmacy Advisory Committee c/o University of Arkansas System Administration 2404 N. University Ave Little Rock, AR 72207

or

Fax: 501-686-2939