

**Stanislaus County Health Services Agency  
Non-Formulary Medication Request Form**

**Fax Completed form to: 558-5631  
Attn: Pharmacy/Medical Director  
Pharmacy Phone: 209-558-5601**

**Medical Director Phone: 209-558-7163  
Medical Director Fax: 209-558-7123**

**Purpose:**

This form is to be used to obtain coverage for a non-formulary drug for which there is no suitable alternative available on the approved formulary

**Review Criteria:**

The following criteria is used in reviewing medication requests:

1. The use of the formulary agents is contraindicated in the patient.
2. The patient has failed an appropriate trial of the formulary agents.
3. The choices available in the drug formulary are not suited for the present patient care need and the drug selected is required for patient safety.
4. The use of the formulary agents may provoke an underlying medical condition that would be detrimental to patient care.

**Medication Request Information:**(please complete each section of this form)

Patient Name: \_\_\_\_\_

UPI/MR#: \_\_\_\_\_

DOB: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Medication Requested: \_\_\_\_\_

Strength: \_\_\_\_\_

Quantity: \_\_\_\_\_

Duration of Treatment: \_\_\_\_\_

Directions: \_\_\_\_\_

Justification for use: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Physician Signature: \_\_\_\_\_  
(Please Print)

Date: \_\_\_\_\_ Phone/Pager: \_\_\_\_\_

*For HSA Utilization Review Only:*

**Provider:** Your Request is:  
\_\_\_\_ Approved as Requested  
\_\_\_\_ Approved as Modified  
\_\_\_\_ Denied

Comments/Explanation  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TAR Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_