

This form must be completed and emailed to nonformulary@childrensnational.org in order to guarantee that the Non-formulary medication requested will be available. Orders should not be verified or entered into the computer system until the medication is present in the Pharmacy. Please allow 3 business days to obtain non-formulary medication.

**LIP COMPLETING FORM**

|  |  |  |
| --- | --- | --- |
| Name  | Pager number  | Date |
| Attending Physician | Pager number | Date  |

**PATIENT INFROMATION**

|  |  |  |
| --- | --- | --- |
| Name (first) | Last | Location |
| Account Number | MRN number  |

**LIP USE ONLY NON-FORMULARY MEDICATION REQUESTED**

|  |  |  |
| --- | --- | --- |
| Trade Name | Generic Name | Dose |
| Route  | Frequency | Duration of Therapy |
| Rationale for Non-Formulary Medication Please provide literature to support the indication.  |
| Is this Medication Request a Home Medication? [ ]  Yes [ ] NOIf yes, can patient bring in their own supply?  [ ]  Yes [ ] NO |

**PHARMACY USE ONLY**

|  |
| --- |
| Name of Formulary Equivalent recommendedRecommending Pharmacist |
| Approved ByRationale  |

**FOR PHARMACY BUYER USE ONLY**

|  |  |
| --- | --- |
| Date Ordered | Date Received  |
| NDC # | AWP Cost/Unit |