

This form must be completed and emailed to [nonformulary@childrensnational.org](mailto: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 NO  If yes, can patient bring in their own supply?  Yes NO | | |

**PHARMACY USE ONLY**

|  |
| --- |
| Name of Formulary Equivalent recommended  Recommending Pharmacist |
| Approved By  Rationale |

**FOR PHARMACY BUYER USE ONLY**

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