***This form must be legibly completed in its entirety***

NON-FORMULARY MEDICATION REQUEST FORM

Name of Facility: Mecklenburg County Jail Central - NCMC Date Requested: / /

Return Fax Number:

Inmate Name: Inmate #:

 Initial Treatment  Renewal

Medication Requested: Strength: Duration:

Medical Condition Being Treated:

Directions:

Prescriber:

Formulary Medications Previously Tried:

Reason non-formulary 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:

**Site Medical Director**

 Approved as Requested

 Approved with Modifications

 Denied

Explanation:

Name:

Signature:

Date:

Comments:

**Regional Medical Director**

 Approved as Requested

 Approved with Modifications

 Denied

Explanation:

Name:

Signature:

Date:

Instructions:

1. Fax Denied/Modified requests to the facility for Medical Director Review.
2. Fax a copy of form to the corporate office: Attn: Director of Pharmacy.