APPENDIX 2: NON-FORMULARY DRUG JUSTIFICATION FORM

TEXAS DEPARTMENT OF MENTAL HEALTH
AND MENTAL RETARDATION

Non-*Formulary* Drug Justification

Facility/Component ____

Drug Name____
(Generic) (Trade) (Strength) (AHFS Therapeutic Class)

The purpose of the *Formulary* is to ensure that the treatments available to TDMHMR consumers are consistent with need, effectiveness, risk, and cost. Exceptions to the *Formulary* are limited to the three categories listed below.

This request is for:

- ☐ an individual patient treatment course. Is this ☐ chronic or ☐ acute therapy?
- ☐ more than one patient/course of therapy. It is estimated that _________ patients will be treated with this drug. Is this ☐ chronic or ☐ acute therapy?

Reason for request:

- ☐ An illness for which no *Formulary* drug is as safe or effective.
- ☐ A trial supply in anticipation of application to *Formulary*.
- ☐ To prevent interruption of course of therapy established prior to admission.

Quantity Ordered	**Cost/ Unit**	**Total Purchase Cost**	***Estimate Course Chronic Cost Per Month**	***Estimate Course Acute Cost**

☐ Alternative drugs are available on the *TXMHMR Formulary*.

_______________________________________ ____________________
Attending Physician (signature) Date

Was the drug ordered ☐ yes or ☐ no?

☐ AGREE ☐ DISAGREE

____
Pharmacy Director or designee (signature) Date

☐ APPROVED ☐ DISAPPROVED ☐ EMERGENCY
Facility clinical/medical director's approval must be obtained within three working days.

____
Facility clinical/medical director or designee (signature) Date