

GHI Pharmacy and Therapeutics Committee
Non-FDA Approved Drug Use and/or Dose Request Form

Attach a *minimum* of two documenting peer-reviewed journal articles/abstracts (with entire citation) in support of the drug for the intended off-label use and/or off-label dosage.

TODAY'S DATE: _____

Patient Name: _____	GHI ID#: _____	DOB: _____
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Prescriber's Name: _____ Specialty: _____

Phone #: _____ Fax #: _____ E-mail: _____

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<u>Requested Drug</u> <i>(include dose, route, and duration)</i> _____

<u>Requested Diagnosis</u> _____
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Other medications (formulary/non-formulary) the patient has used for this same indication and reason for discontinuation: _____ _____
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Patient history that supports your drug &/or dose request (e.g. concurrent disease states, lab tests). Attach documentation when indicated: _____ _____
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Prescriber's Signature: _____ Date: _____

Please provide All pertinent information <u>along with</u> this form to: GHI/GHI HMO Pharmacy Services, 55 Water Street, 12 th Floor South, New York, NY 10041 Telephone No. 1-877-444-3657 Fax to: 1-877-300-9695
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