University of Arkansas Pharmacy Advisory Committee Formulary Request

Member Named_____

Member ID _____ Date of Birth _____

Member Address _____

Date of Request_____ Medication Name _____

Physician Name _____ Telephone No._____

Physician Address _____

Reason for request _____

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____ *Individual Review Request : Reason for request must be accompanied by a copy of the member's chart notes documenting adverse reaction, un-tolerated side effects or member non-response to the preferred medication. If an uncommon side effect is being documented, a completed FDA MedWatch form must also be attached.*

____ *Plan Design Review : Documentation such as new clinical studies or nationally recognized guidelines must accompany requests for formulary replacement for a perceived clinically superior medication.*

Documentation and completed forms should be sent to :

The UofA Pharmacy Advisory Committee
c/o University of Arkansas System Administration
2404 N. University Ave
Little Rock, AR 72207

or

Fax: 501-686-2939