

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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ *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