EmblemHealth®

PHARMACY AND THERAPEUTICS COMMITTEE

Non-FDA-Approved Drug Use and/or Dose Request Form

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

Please print clearly.

Today's Date:	Patient's Name:	Patient's ID #:	Patient's DOB:
Prescriber's Name:			Specialty:
Address:			
Phone #:	Fax #:		Email:

Requested drug (include dose, route and duration):
Requested diagnosis:
Other medications (formulary/nonformulary) the patient has used for this same indication and reason for discontinuation:
Patient history that supports your drug and/or dose request (e.g., concurrent disease states, lab tests). Attach documentation, as appropriate.

Prescriber's Signature:	Date:

Please submit completed form and supporting documentation to EmblemHealth by fax to Clinical Pharmacy at **1-877-300-9695**, by email to **clinicalpharmacy@emblemhealth.com** or by mail to EmblemHealth, Attn: Clinical Pharmacy Department, 441 Ninth Avenue, New York, NY 10001. If you have any questions, please call **1-877-362-5670**.

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