

PM FORM 3.16.4

NARBHA MEDICATION/LAB PHARMACY
EDIT NOTIFICATION FORM

TO: Northern Arizona Regional Behavioral Health Authority
FAX: (928) 913-0399 ATTN: MIS Specialist Unit

FROM: Name: _____ Clinic/Site: _____

DIRECTIONS: Use this form to: 1) request a restricted, non-formulary or brand name med; 2) to receive "more than 30 day supply" of meds; 3) to receive an early medication refill.

Client Name:	_____	Client ID:	_____
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(A) RESTRICTED MEDICATION/LAB, NON-FORMULARY or BRAND(generic available).

Medication/Lab: _____ QTY/Dosage: _____

Medication/Lab: _____ QTY/Dosage: _____

Reason for Request (transition to formulary medication, allergies/reactions/failures to ALL other meds in the class of medications, age limitations) : _____

Start and End Dates (Required): _____

(B) "REFILL TOO SOON" OVERRIDE REQUEST or MORE THAN 30 DAY SUPPLY

Medication 1: _____ QTY/Dosage: _____

Medication 2: _____ QTY/Dosage: _____

Medication 3: _____ QTY/Dosage: _____

Medication 4: _____ QTY/Dosage: _____

Reason for Request: _____

REQUESTING PRESCRIBER

Signature: _____ Date: _____

Not Entered Entered Entered with special limitations: _____

_____ Date: _____

Signature NARBHA Medical Director/MIS Designee