Oregon Department of Corrections
Health Services Section

Non-Formulary Medication Exception Request _____
Institution

Please fill out all entries. Incomplete forms will not be processed. This order form must be filled out and signed by the Practitioner and Designated Reviewer at each Institution. The request is valid for the duration of the order.

Non-Formulary Medication Requested:	
Dx for which med is required:	
Reasons Formulary Medication not used:	
Provider Signature:	**Date:**
URGENT NEED: ☐ **< 24 hrs** ☐ **< 7 days**	
Comments:	
Reviewer Signature:	**Date:**
To Med Review Committee: ☐ **Yes** ☐ **No, Urgent Medication**	
***Medication Review Committee Comments*:**	
Approved: ☐ **yes** ☐ **1 Mo** ☐ **3 Mos** ☐ **6 Mos** ☐ **1 Yr** ☐ **Other** _____ ☐ **not medically indicated**	
Signatures:	**Date:**

Name: _____

SID#:_____

DOB:_____