

Dear Provider,

Columbia Health Medical Services is committed to providing safe and effective care to all eligible Columbia University students. Our facility serves numerous students who request administration of therapeutic medication injections or non-formulary medication prescribed by outside specialists. Collaboration with specialists is essential to ensure the safety of our students. To facilitate clear communication and a shared understanding of the treatment plan, we utilize a Non-Formulary Medication Administration Form (see following page) for every student receiving non formulary medication at our clinic. All patients receiving such medications must have a completed form on file prior to receiving services.

1. Your patient is responsible for providing the medication.
2. The medication must be clearly labeled with:
 - a. Patient's name
 - b. Name of the medication
 - c. Expiration date
3. The Columbia Health Medical Services **Non-Formulary Medication Administration Form** (see following page) must be completed by the student's New York State-licensed specialist prior administration at Columbia Health. This form must be updated annually or with any changes regarding dosage administration.

This form may be submitted:

- a. By the patient, on their next visit to Medical Services.
 - b. By the patient, by uploading to the "Downloadable Forms" section of the Patient Portal
 - c. By the prescribing provider, via secure fax to 212-851-2477.
4. Please forward consultative notes to our office.

Your assistance in completing this form is required to initiate or continue administration of medications ordered by external prescribers and specialists at Columbia Health Medical Services.

We are grateful for your collaboration and your understanding that completion of the Non-Formulary Medication Administration Form is required for Columbia Health Medical Services to deliver this service safely. Please contact me with any questions.



Dr. Urmil Desai

Associate Vice President, Medical Services and Medical Director

Non-Formulary Medication Administration Form

SECTION I.

To be completed by ordering prescriber

Patient Information

Legal Name: _____ Date of Birth: _____

Address: _____

Telephone number: _____ Email: _____

Ordering prescriber information

Name of prescriber: _____ Specialty: _____

Address: _____

Telephone number: _____ Fax number: _____

New York State License #: _____ DEA #: _____

Medication order

Diagnosis: _____

Medication Name	Strength/ Concentration	Dose	Frequency	Route of administration	Date last dose was administered

Date of initiation of medication: _____ Duration the medication will be given? _____

Date of last administration of medication: _____

Allergies (i.e., medication, food, material, environment): _____

Required assessment or screening prior to administration of medication, including:

- a. Side effects: _____
- b. Contraindication: _____
- c. Lapses in timing of administration: _____
- d. Other: _____

Are there additional protocols that need monitoring (i.e., labs)? This will be ordered by prescriber.

Frequency of follow-up appointments with prescriber/specialist (if applicable):

Additional information:

Signature of prescriber

Date

Stamp

SECTION II.

To be completed by Columbia Health Medical Services Pharmacy Committee Member

Is the medication ordered by a New York State licensed prescriber? _____

Date a new medication order must be obtained: _____

Comments:

Decision: Approved Not approved

Signature of reviewing MD/DO/NP

Print Name

Date

Signature of reviewing RN

Print Name

Date