

**Pharmacy Services: Non-FDA Approved Drug  
Use and/or Dose Request Form**

**Attach a minimum of two documenting 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.*

Prescriber's Name: \_\_\_\_\_

Specialty: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Member's Name: \_\_\_\_\_

ConnectiCare VIP ID#: \_\_\_\_\_

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Requested Drug (include generic name, dose, route and duration):

\_\_\_\_\_  
\_\_\_\_\_

Requested Use and/or Dose:

\_\_\_\_\_  
\_\_\_\_\_

Other medications (formulary/non-formulary) the patient has used for this same indication and reason for discontinuation:

\_\_\_\_\_  
\_\_\_\_\_

**Attach the patient history that supports your request for use of the drug and/or dose (e.g., concurrent disease states, lab tests, etc.)**

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Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please submit completed form to ConnectiCare, Pharmacy Services, Attn: Clinical Department,  
55 Water Street, New York, NY 10041.  
Or, fax to ConnectiCare Clinical Pharmacy Services at 1-877-300-9695.**