

**Dallas County Health and Human Services
Grants Management Division
Administrative Agency (AA)**

**LOCAL AIDS PHARMACEUTICAL ASSISTANCE PROGRAM (LPAP)
REQUEST TO REMOVE MEDICATION FROM APPROVED FORMULARY**

Advance Approval Required - All sections must be completed. Printed or Typewritten responses only

NAME OF SUBRECIPIENT (AGENCY):

****DO NOT INCLUDE PATIENT'S NAME ON THIS FORM****

LPAP FORMULARY REMOVAL REQUEST:

MEDICATION GENERIC NAME:	
MEDICATION BRAND NAME:	

Drug Classification (check one):

Analgasic Agents	Anti-Viral Agents: Herpes/CMV Disease	Gastrointestinal Agents
Anti-Depressants / Psychotropic / CNS Agents	Bronchial Dilators / Respiratory Agents	Non-Steroidal Anti-Inflammatory Drugs (NSAID)
Anti-Hyperlipidemic Agents	Dermatological Agents	Other Antimicrobial Agents
Anti-Hypertensive / Cardiac Agents	Diabetes Agents	Vaccines
Anti-Neoplastic Agents	Endocrine / Metabolic Agents (Steroids)	

JUSTIFICATION (Why medication should be removed from formulary – please provide a detailed description):

Justification for category and benefit with literature:

By: _____
Clinician Name
Licensure
Signature
Date

Must be approved by applicable Agency clinician (MD, DO, NP, PA, Pharmacist)

**Submit to Dallas County Health and Human Services, Grants Management Division via fax
to [Angela Jones \(214\)-819-6023](tel:214-819-6023) or email RWLPAP@dallascounty.org**

(Submitted by)
 Name (print) _____ Fax # _____ Phone # _____

Signature _____ Email _____ Date _____

APPROVED **DISAPPROVED**

 Quality Assurance Advisor, Grants Management Division

 Date