
# Non-Formulary Medication Request

**Member Name:** _____

**MedStar Family Choice ID #:** _____

**DOB:** _____

**Provider Name/Office:** _____

**Provider Phone:** _____

**Medication Requested:** _____

**Diagnosis:** _____

**Medical Reason for non-formulary request:**

_____

_____

_____

_____

**Pharmacy Name and Phone:** _____

_____

Please fax this information to the MedStar Family Choice Pharmacy Nurse at (410) 933-2274.

Submit