State Medical Board of Ohio
30 East Broad Street, 3rd Floor
Columbus, OH 43215
med.ohio.gov

Physician Assistant Formulary Request

Completed forms should be emailed to contact@med.ohio.gov

REQUESTOR INFORMATION

Full name: _____
Last First Middle Suffix (Jr., II)

Title/Position: _____ Ohio License Number: _____

Email: _____ Telephone number: _____

Personal address: _____
Number/Street City State ZIP Code

Practice address: _____
Number/Street City State ZIP Code

DRUG INFORMATION

Drug Requested: _____ _____
Brand Name Generic Name

If currently on the formulary, list the authority status quo:

Requested authority:

FDA- approved indications for use (attach most recent FDA-approved label):

Other indications for use (attach peer-reviewed, evidence-based literature which emanates from a recognized body of knowledge establishing that the off-label use is supported):

Estimated frequency of use in your practice (i.e., number of patients in next six months):

Is it more efficacious than other drugs currently on the formulary and why?

Are there special precautions or side effects?

Will the physician assistant's use of the drug be according to a protocol approved by the supervising physician and/or medical committee(s) of the facility?

_____ _____
Signature of Physician Assistant (if applicable) Date

_____ _____
Signature of Supervising Physician Date