Nebraska Mental Health Board Prescription Assistance Program (The LB 95 Program)

Procedure for requesting addition to the LB 95 List of Available Medications

1. A physician, APRN, or PA-C may request a drug for formulary addition by completing the Formulary Addition Request Form and the Disclosure Form. Requests will only be evaluated upon the completion of these forms.

2. The form is mailed or faxed to:

Lincoln Regional Center Pharmacy
801 West Prospector Place
Lincoln, NE 68522

Fax: (402) 479-5438

3. The request will be reviewed by the LB 95 Oversight Committee and a determination will be made whether to include the drug, include the drug on a limited basis, or not include the drug.

4. Changes to the List of Available Medications will be updated on the website within 30 days.

FORMULARY ADDITION REQUEST FORM

1. Name of requested drug:

2. Dosage forms and strengths:

3. FDA-approved indications:

4. Comparable drugs on the formulary:

5. Clinical situations in which the requested drug is superior to current formulary drugs:

6. Known toxicity, adverse drug reactions, and drug interactions:

7. Potential for error in prescribing or ordering, preparation, dispensing, and administration and/or abuse:

8. Which (if any) of the formulary drugs may be deleted at the addition of the drug requested?

9. Anticipated frequency of use (number of patients, duration of therapy, etc.):

10. Cost:

Requested by:_____ _____Date:_____

Signature:_____

Requestor's Mailing Address, Phone and Fax Number, Email Address:

DISCLOSURE FORM

Potential Conflict of Interest Disclosure

___Yes___No In the past 24 months, have you or your practice received research support or other financial support from the manufacturer of this requested drug? If yes, please explain:

___Yes___No I have a consulting agreement with the manufacturer of this requested drug. If yes, please explain:

__Yes___No I am a member of an advisory board, speakers bureau, or consulting panel for the manufacturer of this requested drug. If yes, please explain:

___Yes___No I, spouse, or dependent have a financial interest in the manufacturer of this requested drug. If yes, please explain:

__Yes___No I have potential conflict of interest not implied above related to this requested drug. If yes, please explain:

Requestor's Signature:_____ Date:_____