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

LOCAL AIDS PHARMACEUTICAL ASSISTANCE PROGRAM (LPAP)
REQUEST TO ADD MEDICATION TO 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 ADDITION REQUEST:

MEDICATION GENERIC NAME:	
MEDICATION BRAND NAME:	

Drug Classification (check one):					
	Analgesic 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 (How medication is related to the treatment of HIV – 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 or email RWLPAP@dallascounty.org

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

Signature _____ **Email** _____ **Date** _____

☐ **APPROVED** ☐ **DISAPPROVED**

_____ _____
Quality Assurance Advisor, Grants Management Division **Date**