SANTA CLARA VALLEY MEDICAL CENTER
DEPARTMENT OF PHARMACY SERVICES

MAXIUM DAILY DOSE (MDD) EXCEED REQUEST

Patients Name:_____MR#/Unicare#:_____

Site/Nurs/Unit:_____

1. Diagnosis:_____

2. Drug Name: Generic_____Brand:_____

3. Dosage Form:_____Strength:_____

4. Dosage Schedule:_____

5. Approximate Duration of use:_____

6. Clinical Justification: Please state reason (s) for exceeding the maximum daily dose

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Requesting Physician:_____M.D. Date:_____

Approved for use:_____

Not approved for use:_____

Medical Director:_____M.D. Date:_____

1. PLEASE FILL OUT COMPLETELY, FAX TO EITHER ENBORG LANE PHARMACY AT (408) 885-4109 OR DOWNTOWN PHARMACY AT (408) 287-5740
2. PHARMACY STAFF WILL FAX TO MEDICAL DIRECTOR OFFICE AT (408) 885-7583
3.THEN MEDICAL DIRECTOR OFFICE WILL FAX THE APPROVED/UNAPPROVED FORM BACK TO APPLICABLE PHARMACIES WITH THEIR ABOVE FAX NUMBERS.