## APPROVED FORMULARY for
## Physician Assistant Registered to Physician

(Adopted by the Alabama Board of Medical Examiners March 15, 1995)

I authorize _____, P. A., to prescribe and/or administer medications in the categories* below. *[You must complete each line with **YES**, **NO**, or **RESTRICTED**. If restricted, state restrictions below.]*

* ***Authorized categories of drugs should reflect the needs of the medical practice*** **in which the Physician Assistant is working**.

* **Botox, Restylane, Collagen and Mesotherapy are not approved for PA prescriptive privileges nor are they to be administered by a P. A.**

* The category, *Radioactive Agents*, shall be approved by the Alabama Board of Medical Examiners only for a P. A. certified to a supervising physician who holds a current license from the Alabama Public Health Department for prescribing/administering/dispensing radioactive pharmaceuticals. If the category, Radioactive Agents, is requested, please attach a copy of the physician's current license from the Public Health Department.

All written prescriptions will adhere to the standard, recommended doses of legend drugs, as identified in the Physician Desk Reference or Product Information Insert, not to exceed the recommended treatment regimen periods.

1. Antihistamine and Decongestant Drugs _____
2. Antineoplastic Agents (If yes, **specify circumstances)** _____

_____

3. Blood Derivatives _____
4. Coagulation Agents _____
5. Central Nervous System Agents (non-scheduled) _____
6. Agents of Electrolytic, Caloric and Water Balance _____
7. Expectorants and Cough Preparations (non-scheduled) _____
8. Gastrointestinal Drugs _____
9. Heavy Metal Antagonist (If yes, **specify circumstances)** _____

_____

10. Local Anesthetics _____
11. Radioactive Agents **(see note at top of form)** _____
12. Spasmolytics _____
13. Vitamins _____
14. Anti-Infective Agents _____
15. Autonomic Drugs _____
16. Blood Formation _____
17. Cardiovascular Drugs _____
18. Diagnostic Agents _____
19. Enzymes _____
20. Ophthalmic drugs _____
21. Gold Compounds (If yes, **specify circumstances)** _____

_____

22. Hormone and Synthetic Substitutes _____
23. Birth Control Drugs and Devices _____
24. Oxytocics (If yes, **specify circumstances)** _____

_____
25. Serums, Toxoids, Vaccines _____
26. Analgesics and Antipyretics (non-scheduled) _____
27. Prosthetics/Orthotics _____
28. Pulmonary Drugs _____
29. Anti-inflammatory Drugs _____
30. Other _____

_____

_____

Restrictions: _____

_____

_____

**THE PHYSICIAN ASSISTANT NAMED IN THIS DOCUMENT IS NOT AUTHORIZED TO PRESCRIBE CONTROLLED DRUGS.**

_____, M.D./D.O. _____
Physician signature Date

_____ _____
Physician Assistant Signature Date

**THE SUPERVISING PHYSICIAN SHALL BE HELD LIABLE OR RESPONSIBLE FOR ANY ACT OR OMISSION OF THE ASSISTANT ARISING OUT OF THE ASSISTANT'S PRESCRIBING TO PATIENTS.**