UNITED STATES PROBATION AND PRETRIAL SERVICES
DISTRICT OF UTAH

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MEDIATION REIMBURSEMENT REQUEST FORM

Client Name:
PACTS #
Treatment Facility:

Name of Non-Psychotropic Medication:	
The above non-psychotropic medication has been prescribed to treat the following condition:	
Provide brief rationale for off-label use of this medication:	
Prescribing physician:	
Pharmacy Name and Address:	

Authorizing signature (Treatment Facility) _____ Date _____

USPO Referral Agent (KP or CH) _____ Date _____

USPO Contracting Officer or COTR _____ Date _____

** IMPORTANT** IF THIS FORM IS NOT FILLED OUT IN ITS ENTIRETY, THE COST OF THE PRESCRIPTION WILL NOT BE REIMBURSED.
When completed, please submit with the appropriate month's invoice.