



INLAND EMPIRE HEALTH PLAN

Please Print

PER #: \_\_\_\_\_  
(For IEHP Use Only)

**SUPPLEMENTAL PHARMACY EXCEPTION REQUEST (PER) FORM  
FOR COMPOUNDED PRESCRIPTION**

FAX TO: IEHP

FAX #: (909) 890-2058

Member Name:	ID:
DOB:	

Please list all ingredients and costs for the requested prescription.

**Prescription**

Ingredient	Cost

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