



INLAND EMPIRE HEALTH PLAN

Please Print

PER #: \_\_\_\_\_

(For IEHP Use Only)

### PHARMACY EXCEPTION REQUEST (PER) FORM

FAX TO: IEHP

FAX #: (909) 890-2058

#### IEHP MEMBER

Member Name: \_\_\_\_\_ ID#: \_\_\_\_\_ DOB: \_\_\_\_\_ M F  
 Other ID: \_\_\_\_\_ Phone#: \_\_\_\_\_

#### PHYSICIAN

Prescribing Physician: \_\_\_\_\_ MD State License #: \_\_\_\_\_ MD Specialty: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

#### PHARMACY

Pharmacy Name: \_\_\_\_\_ Pharmacy NABP #: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

#### FORM

Form Completed By: \_\_\_\_\_ Today's Date: \_\_\_\_\_

#### PRESCRIPTION

Rx #: \_\_\_\_\_ Date of Original Rx: \_\_\_\_\_  
 Medication: \_\_\_\_\_  
 Strength: \_\_\_\_\_ Quantity: \_\_\_\_\_ Refills Remaining: \_\_\_\_\_  
 NDC #: \_\_\_\_\_ Directions: \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_  
 Previous Therapy: \_\_\_\_\_  
 Medical justification for non-formulary drug: \_\_\_\_\_

Your request is:  Approved  Modified  Request for More Information  Misdirected  Denied

Valid from: \_\_\_\_\_ Expires on: \_\_\_\_\_ Decision by: \_\_\_\_\_ Date: \_\_\_\_\_

#### Request for Expedited Review (For IEHP Medicare DualChoice Members Only)

**REQUEST FOR EXPEDITED REVIEW (24 HOURS)**

▶ BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

Please submit Request promptly to avoid any delays in patient care. IEHP will respond to the request within one working day. Providers should exercise appropriate clinical judgment in dispensing medication pending PER approval.

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