



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
SSN#: _____

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 #: _____ SIG: _____
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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P.O. Box 19026, San Bernardino, CA 92423-9026
Tel (888) 860-1297 Fax (909) 890-2058
Visit our web site at: www.iehp.org