SIERRA Rx
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Exception Request Form

☐ Standard ☐ Exped te

Member Name: _____ Date of Request _____

Member #: _____ M / F DOB: _____

Documented Allergies: _____

Physician Information - COMPLETE INFORMATION IS REQUIRED TO RECEIVE RESPONSE

Physician Name (please print clearly): _____

Physician Signature: _____ DEA No.: _____

Phone: _____ FAX: _____

Address: _____

Office Contact Person _____

Requested Medication

Drug name, strength, quantity, directions and duration of treatment: _____

One drug request per form please

Additional Information: The following information must be included or request will be returned. (Please, when available, attach copies of office notes documenting prior therapy, diagnosis, lab results, etc.)

Diagnosis: _____

_____

Medication History for this Diagnosis:

Drug	Daily Dose	Started	Stopped	Reason for discontinuing medication:
_____	_____	__/__	__/__	_____
_____	_____	__/__	__/__	_____
_____	_____	__/__	__/__	_____

Clinical Rationale/Supporting Documentation: Why do you feel this drug is superior to current Preferred Drug(s)? (documented efficacy in this patient, documented failure or allergy of preferred meds, etc.)

_____

_____

PHONE: (702) 242-7050 or (800) 925-7455
FAX to: (702) 341-7566 or (877) 219-1612
or MAIL to: SHL - PHARMACY SERVICES
Attn: Medical Necessity
P.O. Box 15645
Las Vegas, NV 89114-5645

FOR OFFICE USE ONLY

( ) SXC review
( ) NOT APPROVED
( ) APPROVED
#: _____
Term Date: _____
Date Claim Paid: _____
Tier Status: _____

( ) Need more info
( ) Does not meet criteria
( ) Alternative available
( ) Not met 9 month moratorium

_____

_____

_____