

Medical Necessity Request Form [Applicable for HPN/SHL Commercial/Medicaid members only]

Member Name:				Date of Request
Primary Cardholder #:				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 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, option #6 (800) 443-8197, option #6

FAX to: (702) 242-6751 or (800) 997-9672

OR Mail to: HPN/SHL - PHARMACY SERVICES

Attn: Medical Necessity

P.O. Box 15645

Las Vegas, NV 89114-5645