HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

Pharmacy Services

Medical Necessity Request Form

[Applicable for HPN/SHL Commercial/Medicaid members only]

	STANDARD		EXPEDITE

Member Name: _____ Date of Request _____

Primary Cardholder ID #: _____ 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)? (Include 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 : (702) 242-6751
(800) 997-9672

OR Mail to: HPN/SHL - PHARMACY SERVICES
Attn: Medical Necessity
P.O. Box 15645
Las Vegas, NV 89114-5645