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2023 SHL Provider Summary Guide

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| | or tap here to er | | | | | Click o | r ta | ap he | re to | ente | er te | xt. | | Cli | CK OI | r tap h | ere | to enter | text. |
| (6) Frequency/Quantity/Repetition Request: Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | |
| a. Does this service involve multiple treatments? | | | | | | Υ | es: | | | No: If "No," skip to Section | | | | | | 7. | | | |
| b. Type of Service: Click or tap here to enter text. | | | | | | | c. Name of Therapy/Agency: Click or tap here to enter text. | | | | | | | | | | ter | | |
| d. Units/Volume/Visits Requested: Click or tap here to enter to | | | | | | enter t | ext | e. Frequency/Length of Time Needed: | | | | | | Cl | ick o | r tap l | here | to ente | r text. |
| (8) Pr | escription Drug | : | С | lick or | tap he | re to e | ent | er te | xt. | | | | | | | | | | |
| a. Dia | gnosis Name ar | nd Cod | e: C | lick or | tap he | re to e | ent | er te | xt. | | | | | | | | | | |
| b. Patient Height (if required): Click or tap here to enter text. | | | | | r text. | | C | . Pat | ient equi | | _ | Clic | k or | tap l | nere to | o en | ter text. | | |
| - | ute of Administ | ration: | | Ora | al/SL: | | T | opica | | | | ectio | n: | | IV: | | Ot | ther*: | |
| *Plea | se explain if "ot | ther:" | Cli | ick or t | tap her | e to er | nte | r text | t. | l | | | | | | | | | |
| | | Doctor | | - | | Dialysis | | | | | Hor | ne H | ealth | Hos | pice | : 🗆 | Ву | / Patient | : 🗆 |
| f. Medication Requested g. Strength (include both loading and maintenand dosage) | | | | | | | h. Dosing Schedule | | | | | i. Quantity per month or Quantity Limits | | | | | | | |
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| j. Is th | e patient curre | ntly tr | eated | with | the req | ueste | d n | nedic | ation | n(s): | | | | Ye | s*: | | | No: | |
| *If "Y | es," when was t | the tre | atmei | nt wit | h the r | equest | ted | med | licati | on st | tarte | d? D | ate: | Cli | ck or | tap h | ere | to enter | text. |
| k. Ant | icipated medica | ation s | tart d | late (N | /M/DD |)/YY): | | Cl | ick o | r tap | here | e to e | nter | text. | | | | | |
| | eral prior autho | | - | - | - | | | | | n(s) | for t | he re | ques | ted | medi | ication | ns, ir | ncluding | an |
| | nation for selec | | | nedica | tions o | ver alt | ter | nativ | es: | | | | | | | | | | |
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| п. ка | tionale for drug Alternative dr | ug(s) c | | | | | _ | | | | ith a | dver | se ou | tcon | ne, e | .g., to | xicit | y, allerg | y, or |
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| | Please specify | | icated | d or tr | iod. | | | | | | | | | | | | | | |
| (1) Drug(s) contraindicated or tried;(2) Adverse outcome for each; | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | |
| | (3) If therapeu | | | | of the | ару о | n e | ach c | drug(| s). | | | | | | | | | |
| | Patient is stab | | | | | | | | | | erse | clin | ical o | utco | me v | with m | nedi | cation cl | nange. |
| | Specify anticip | oated s | ignific | cant a | dverse | clinica | al o | utco | me: | Cli | ick o | r tap | here | to e | nter | text. | | | |
| | Medical need | for dif | ferent | t dosa | ge and | or hig | ghe | er dos | sage. | | | | | | | | | | |
| | Specify: (1) Do | sage(s |) tried | d; (2) I | Explain | medic | cal | reas | on: | Cli | ick o | r tap | here | to e | nter | text. | | | |
| | Request for fo | rmulai | v exc | eptio | n. Pleas | se spec | cif | / : | | | | | | | | | | | |

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| | (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) If therapeutic failure, length of therapy on each drug and adverse outcome; (3) If not as effective, length of therapy on each drug and outcome. | | | | | | | | | | Click or tap here to enter text. | | | | |
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| | Other. Please | • | | | | nter text. | | | | | | | | | |
| n. List | t any other med | dications pa | tient w | ill use in | combi | nation w | ith req | ueste | d medic | ati | ion: | | | | |
| Click | or tap here to e | nter text. | | | | | | | | | | | | | |
| o. List | t any known dr | ug allergies: | Cl | ick or tap | here ' | to enter t | ext. | | | | | | | | |
| | evious services ce/therapy)? | therapy (ir | cluding | g drug, do | ose, du | ırations, a | and rea | ason 1 | for disco | nt | inuing each previous | | | | |
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| C. | Click or tap her | re to enter to | ext. | | | | Date I | Disco | ntinued: | : | Click or tap here to enter text. | | | | |
| | | | | | | | | | | | | | | | |
| • | (10) Attestation: I hereby certify and attest that all information provided as part of this prior authorization is true and accurate. | | | | | | | | | | | | | | |
| Requester Signature: Click or tap here to enter text. | | | | | | | Date: | | | Click or tap here to enter text. | | | | | |
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| | DO NOT WRITE BELOW THIS LINE. FIELDS TO BE COMPLETED BY PLAN. | | | | | | | | | | | | | | |
| Autho | enter te | Contact | ct Name: Click | | | · ta | p here to enter text. | | | | | | | | |
| Contact's credentials/designation: Click or tap here | | | | | | | er text. | | | | | | | | |
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