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To file electronic	ally, a	attach t	to requ	uest s	ubmitte	l in w	eb po	ortal.	To fi	le via	a facsir	mile, sen	d to	1-800)-282-884	5
To contact the co	_			-		-	-					n your me	dical	ID ca	rd betwee	n
(1) Priority and F	reque	ency:	Cli	ick or	tap here	to en	iter te	xt.								
a. Standard	Sei	rvices s	schedu	ıled fo	or this da	te:		Click or ta	ap here	e to e	enter t	ext.				
b. Urgent/Exped	ertifies the health of	•	• •	•	ndard	revie	ew tim	eline ma	y ser	ious	y jeopard	ize				
c. Frequency:	Initia	l: 🗆	Ext	ensio	n: 🗆	Pre	evious	s Authori:	zation	#:	Click	or tap he	re to	ente	r text.	
(2) Enrollee Info	rmatio	on:	Click	or tap	o here to	enter	r text.									
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e. City: Click o text.	r tap h	nere to	enter		f. State		Click text.	or tap he	ere to e	enter	-	g. Zip Co	de:	e: Click or tap here to enter text.		ere
(3) Provider Info	rmatio	on:	О	rderii	ng Provid	er:		Rende	ering P	Provi	der:		Во	Both		
Please note: Exc	therapy Exception requests are limited to members with stage 3 or stage 4 cancer and require the following information: progress notes, laboratory results, radiology results, previous medications, and other factors impacting the plan of care. Processing delays may occur if the requestor (e.g. rendering provider, or member) does not have appropriate documentation of medical necessity. Please note: Requests are reviewed by Registered Nurses, Pharmacists, and Board Certified Oncologists.															
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2024 SHL Provider Summary Guide

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(6) Fre	equency/Quant	(lick or tap here to enter text.																
a. Does this service involve multiple treatments?							Yes:		No: 🗆 If "No," skip to Sec						Section	7.			
b. Тур	b. Type of Service: Click or tap here to enter text.						c. Name of Therapy/Agency:							Click or tap here to enter text.					
	its/Volume/Visi Juested:	ts Cli	ck or t	tap here to	o enter	tex	e. Frequency/Length of Time Needed:					_	C	lick c	or tap	here	to ente	r text.	
(8) Pr	escription Drug		Cli	ck or tap l	nere to	en	ter te	xt.					•						
a. Dia	gnosis Name an	nd Code	: Cli	ck or tap l	nere to	en	ter te	xt.											
	ient Height required):	Click o	tap h	nere to en	ter text.		C	. Pat	ient equi	-	_	Clic	ck or tap here to enter text.						
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j. Is th	ne patient curre	ntly tre	ated v	with the r	equeste	ed i	medic	ation	n(s):				Ye	s*:			No:		
*If "Y	es," when was t	he trea	tmen	t with the	reques	te	d med	licati	on st	arte	d? D	ate:	Cli	ck o	r tap h	ere	to enter	text.	
k. Ant	icipated medica	ation st	art da	te (MM/[DD/YY):		Cl	ick o	r tap	here	e to e	nter	text.	,					
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m. Ra	tionale for drug		_								-l					! - ! •			
	Alternative drugger therapeutic fa		ntrair	idicated c	r previo	ous	siy tri	ea, b	ut w	ith a	aver	se ou	tcon	ne, e	e.g., to	XICIT	ty, allerg	y, or	
	Please specify:																		
	(1) Drug(s) con		cated	or tried;							Clia	l					4		
		Click or t							tap here to enter text.										
	(3) If therapeu																		
	Patient is stab															nedi	cation cl	nange.	
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2024 SHL Provider Summary Guide

	(1) Formular	y or preferre	d drug										
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	(3) If not as effective, length of therapy on each drug and												
	outcome.												
	Other. Please	•				nter text.							
	t any other me	•	tient w	ill use in	combi	nation w	ith req	ueste	ed medic	ati	on:		
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o. Lis	t any known dr	ug allergies:	Cl	lick or tap	here	to enter t	text.						
		s/therapy (in	cludin	g drug, de	ose, dı	ırations,	and re	ason	for disco	nti	inuing each previo	us	
servi	service/therapy)?												
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b.	Click or tap he	re to enter to	ext.				Date	Disco	ntinued	:	Click or tap here to	o enter text.	
c.	Click or tap he	re to enter to	ext.				Date	Disco	ntinued	:	Click or tap here to enter text.		
(10)	Attestation:												
	I hereby certify	y and attest	that all	informa	tion p	rovided a	s part	of thi	s prior a	uth	norization is true a	nd accurate.	
Requ	ester Signature	tap her	e to ente	er text.			Date:			Click or tap here to enter text.			
	DO NOT WRITE BELOW THIS LINE. FIELDS TO BE COMPLETED BY PLAN.												
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