Please Print

RxPA #:_____
(For IEHP Use Only)

SUPPLEMENTAL PHARMACY EXCEPTION REQUEST (PER) FORM

FOR COMPOUNDED PRESCRIPTION

FAX TO: IEHP **FAX #: (909) 890-2058**

Member Name:	ID:
DOB:	

Please list all ingredients and costs for the requested prescription.

Prescription

Ingredient	Cost

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