

Unison Health Plan Pharmacy Department
Medical Exception Worksheet/Prescription Order Form
Specialty Pharmacy (ORAL / INJECTABLE) Medications
Please complete and return fax to 412-457-1328 or 866-639-7785



PATIENT DEMOGRAPHICS / INSURANCE INFORMATION

Patient Name: _____ Unison ID #: _____
 Insured's Name: _____ Insured's SSN/Group #: _____
 Primary Insurance Information: ID #: _____ Group #: _____
 Secondary Insurance Information: ID#: _____ Group #: _____
 Patient Mailing Address: _____ DOB: _____
 Patient Phone day: (_____) _____ Evening: (_____) _____
 Best time to Contact: _____ Sex: M F Primary language: _____

PRESCRIPTION (Required)

Drug/Strength/Dose: _____ Coordinating administration supplies Sig: _____
(As required by PA law, generics will be dispensed if available)
 MD Name: _____ MD Signature (required): _____
 DEA #: _____ MD License #: _____ State Medicaid #: _____
 Physician Address: _____ City, State Zip: _____
 Physician Phone #: (_____) _____ Physician Fax #: (_____) _____

For injectable medications only:
 Medication to be Administered: Physician's Office (**In Office / Outpt Facility**) Patient's Home (**Administered**)
 Deliver Rx to: Physician's Office Patient's Home Other Address: _____
 Contact Person/Ext.: _____ Date Needed: _____ QTY: _____ Duration: _____

CLINICAL INFORMATION

Clinical Diagnosis: _____ ICD-9 Code: _____
Pregnancy Status: YES NO If yes, Expected Due Date: _____
 Please include details of past relevant medical treatment, which substantiates need for exception to using formulary alternatives:
 (i.e. past prescription treatment failures, documented side effects, lab values, etc.)

Formulary Medication Attempted	Dose	Dates of Therapy	Reason for Discontinuing Therapy

Height: _____ Weight: _____ Allergies (including food): _____
 Current Patient Medication Profile including OTCs & herbals: (drug / dose / directions)

 Additional Information: _____

Physician Signature:** By signing above the physician is providing Prescription Solutions with a prescription that can be used to facilitate the dispensing and/or coordination of delivery for the requested medication. The Physician Signature** above is not required if the physician will supply the medication directly to the patient, if the patient has already been provided with a written prescription or if the physician will provide the prescription to a pharmacy via phone or fax.

The purpose of this worksheet is to provide complete information regarding the physician's request for a non-formulary or prior authorization medication. It will be reviewed and notification of approval will be given within 24 hours. Thank you.

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