

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: <input type="checkbox"/> M <input type="checkbox"/> F Primary language: _____

PRESCRIPTION (Required)

Drug/Strength/Dose: _____ <small>(As required by PA law, generics will be dispensed if available)</small>	<input type="checkbox"/> Coordinating administration supplies	Sig: _____
	QTY: _____	Duration: _____
MD Name: _____	MD Signature (required): _____	
DEA #: _____	MD License #: _____	State Medicaid #: _____
Physician Address: _____ City, State Zip: _____		

For injectable medications only:

Medication to be Administered: <input type="checkbox"/> Physician's Office (In Office / Outpt Facility) <input type="checkbox"/> Patient's Home (Administered)
Deliver Rx to: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> Other Address: _____
Contact Person/Ext.: _____ Date Needed: _____

CLINICAL INFORMATION

Clinical Diagnosis: _____	ICD-9 Code: _____		
Pregnancy Status: <input type="checkbox"/> YES <input type="checkbox"/> 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: _____			

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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