

**Unison Health Plan Pharmacy Department
Pharmacy Medical Exception Request Worksheet**
Please complete and return via fax to 412-457-1328 or 866-639-7785



PATIENT NAME _____

D.O.B. ___/___/___ **MEMBER ID#** _____ **DURATION** _____

DRUG REQUESTED _____

DOSAGE and Sig. _____ **FAX ATTENTION:** _____

PHYSICIAN (PLEASE PRINT) _____ **PH#** () _____ **FAX#** () _____

PHYSICIAN ADDRESS _____

***Please Note: ALL are required fields above**
 << Additional Drug Specific forms are available at UnisonHealthPlan.com >>

Clinical Information

Diagnosis relevant to this request: _____

Please include details of past relevant medical treatment, which substantiates need for exception to using formulary alternatives: (e.g. past prescription treatment failures, documented side effects, chart documentation, lab values, etc.):

| Formulary Medication Attempted | Dose | Date(s) of therapy | Reason for Discontinuing Therapy |
|--------------------------------|------|--------------------|----------------------------------|
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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 or denial will be given within 24 hours. Thank you.

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