

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



**17-alpha Hydroxyprogesterone Caproate**

**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: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
 Sex: M F

**PRESCRIPTION (Required)**

Drug/Strength/Dose: \_\_\_\_\_ Sig: \_\_\_\_\_  
 Coordinating administration supplies  
 (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 #: ( ) \_\_\_\_\_  
 Medication to be Administered: Physician's Office Patient's Home  
 Deliver Rx to: Physician's Office Patient's Home  
 Other Address: \_\_\_\_\_  
 Contact Person/Ext: \_\_\_\_\_ Date Needed: \_\_\_\_\_ Duration: \_\_\_\_\_

**INFORMATION REQUIRED**

Does the Patient have a documented history of idiopathic pre-term delivery at less than 37 weeks gestation Yes \_\_\_\_\_ No \_\_\_\_\_  
 Gravidity: \_\_\_\_\_ Parity: \_\_\_\_\_ Due Date: \_\_\_\_\_  
 Gestational age: \_\_\_\_\_ Indication: \_\_\_\_\_

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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