

**Unison Health Plan Pharmacy Department
Medical Exception Worksheet/Prescription Order Form
HEPATITIS C THERAPY**




Please complete and return fax to 412-457-1328 or 866-639-7785

PATIENT DEMOGRAPHICS / INSURANCE INFORMATION

Patient Name _____	Member ID # _____
Patient Mailing Address _____	DOB _____

Patient Phone # _____ (day) _____ (evening)	Primary language _____

PRESCRIPTION [Required]

	DRUG REQUESTED, Sig _____
Physician Name _____	Physician Signature _____ [Signature required]
DEA Number _____	MD License Number _____
Physician Phone # _____	Physician Fax # _____
Physician Address _____	

Anticipated 1 st / Next Injection Date _____	Duration _____
Medication to be Administered:	<input type="checkbox"/> Physician's Office (In Office / Outpt Facility) <input type="checkbox"/> Patient's Home (Self-Administered)
Deliver Product to:	<input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> Other _____
Office Contact Person/Extension _____	

CLINICAL INFORMATION

1. Patient Diagnosis _____
2. Did the patient receive treatment in the past? Yes / No
3. If yes, list regimen and duration. _____

4. Please provide a copy of the following:
(a) Most recent viral load, or HCV RNA report (Please note: for renewal requests, a <i>current</i> report is required.)
(b) Liver biopsy (if available)
(c) Liver function tests (two most recent)
(d) Genotype results
5. 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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