

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 _____ NPI # (Required) _____
Physician Phone # _____ Physician Fax # _____
Physician Address _____
Anticipated 1st / Next Injection Date _____ Duration _____
Medication to be Administered: Physician's Office Patient's Home
Deliver Product to: Physician's Office Patient's Home Other _____
Office Contact Person/Extension _____

CLINICAL INFORMATION

1. Patient Diagnosis \ ICD-9 Code : _____
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 *current* report is required.)
(b) Liver biopsy (if available)
(c) Liver function tests (two most recent)
(d) Genotype results
5. 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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