

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



Thiazolidinediones (TZDs) and
Dipeptidyl peptidase-4 inhibitors (DPP-4s)

PATIENT NAME _____
D.O.B. ___/___/___ MEMBER ID# _____ DURATION _____
DRUG REQUESTED _____
DOSAGE and Sig. (PLEASE PRINT) _____ FAX ATTENTION: _____
PHYSICIAN _____ PH# (____) _____ FAX# (____) _____
PHYSICIAN ADDRESS _____

***Please Note:** ALL are required fields above

<< Additional Drug Specific forms are available at UnisonHealthPlan.com >>

1. Please Circle Patient diagnosis: Type II Diabetes or Type I Diabetes
2. Please document patient's most recent HgbA1C (hemoglobin A1c) _____ (required)
Date _____
3. Is the patient currently taking Glucophage? Circle: Yes or No
If yes, please indicate Glucophage dose, and dates of therapy _____

4. If answer to # 3 is NO, has the patient tried and failed Glucophage? Circle: Yes or No
If yes, please indicate dates of therapy when Glucophage was tried _____
Is Glucophage contraindicated? Circle: Yes or No
If YES, please state reason for contraindication _____

5. Please list all details of this patient's current diabetes medications (medication, dose, and dates of therapy) _____

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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