

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 TZD Combination Products**

PATIENT NAME \_\_\_\_\_  
D.O.B. \_\_\_/\_\_\_/\_\_\_ MEMBER ID# \_\_\_\_\_ DURATION \_\_\_\_\_  
DRUG REQUESTED \_\_\_\_\_  
DOSAGE and Sig. \_\_\_\_\_ FAX ATTENTION: \_\_\_\_\_  
PHYSICIAN (PLEASE PRINT) \_\_\_\_\_ PH# (\_\_\_\_) \_\_\_\_\_ FAX# (\_\_\_\_) \_\_\_\_\_  
PHYSICIAN ADDRESS \_\_\_\_\_  
\_\_\_\_\_  
NPI (Required) \_\_\_\_\_

*\*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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