

**Medical Exception Worksheet/Prescription Order Form  
Specialty Pharmacy (ORAL / INJECTABLE) Medications**



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

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

**PRESCRIPTION (Required)**

Drug/Strength/Dose: \_\_\_\_\_  Coordinating administration supplies Sig: \_\_\_\_\_  
*(As required by PA law, generics will be dispensed if available)* QTY: \_\_\_\_\_ Duration: \_\_\_\_\_  
 MD Name: \_\_\_\_\_ MD Signature (required): \_\_\_\_\_  
 DEA #: \_\_\_\_\_ MD License #: \_\_\_\_\_ State Medicaid #: \_\_\_\_\_  
 Physician Address: \_\_\_\_\_ City, State Zip: \_\_\_\_\_

***For injectable medications only:***  
 Medication to be Administered:  Physician's Office (**In Office / Outpt Facility**)  Patient's Home (**Administered**)  
 Deliver Rx to:  Physician's Office  Patient's Home  Other Address: \_\_\_\_\_  
 Contact Person/Ext.: \_\_\_\_\_ Date Needed: \_\_\_\_\_

**CLINICAL INFORMATION**

Clinical Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_  
**Pregnancy Status:**  YES  NO If yes, Expected Due Date: \_\_\_\_\_  
 Please include details of past relevant medical treatment, which substantiates need for exception to using formulary alternatives:  
 (i.e. past prescription treatment failures, documented side effects, lab values, etc.)

Formulary Medication Attempted	Dose	Dates of Therapy	Reason for Discontinuing Therapy

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Allergies (including food): \_\_\_\_\_  
 Current Patient Medication Profile including OTCs & herbals: (drug / dose / directions)  
 \_\_\_\_\_  
 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.

THE INFORMATION CONTAINED IN THIS FACSIMILE IS CONFIDENTIAL INFORMATION INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY NAMED ABOVE. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, OR THE EMPLOYEE OR AGENT RESPONSIBLE TO DELIVER IT TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION, OR COPYING OF THIS COMMUNICATION IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE IMMEDIATELY NOTIFY US BY TELEPHONE AND RETURN THE ORIGINAL MESSAGE TO US AT THE ABOVE ADDRESS VIA THE U.S. POSTAL SERVICE. ANYONE SO COOPERATING WILL BE REIMBURSED FOR ANY REASONABLE EXPENSE INCURRED. THANK YOU.

**Unison Administrative Services, LLC Pharmacy Department** Unison Plaza, 1001 Brinton Road, Pittsburgh, PA 15221  
 Phone 412-380-6015 or 877-651-2217 fax 412-457-1328 [www.unisonhealthplan.com](http://www.unisonhealthplan.com)