

# Medical Exception Request Worksheet

*Please complete and return via fax to the patient's Health Plan*

**UPMC Health Plan**  
 Fax # (412) 454-7722  
 Phone # (800) 396-4139

**Gateway Health Plan**  
 Fax # (888) 245-2049  
 Phone # (800) 528-6738

**MedPLUS+/MedPLUS+ CHIP**  
 Fax # (412) 457-1328  
 Phone # (877) 651-2217

Date: _____		Patient's Health Plan ID#: _____	
Patient Name: _____			
D.O.B.: _____		Drug Requested: _____	
Strength: _____		Frequency: _____	
Duration: _____			
# of Refills: _____		(Circle One) New or Ongoing Medication: _____	
Physician: _____		Specialty: _____	
Medical License #: _____		Pager #: _____	
Office Contact: _____		Phone #: _____	
Fax #: _____			
Physician Address: _____			
<i>[Office Stamp]</i>			
Pharmacy: _____		Phone #: _____	

## Clinical Information

Diagnosis and rationale relevant to this request: \_\_\_\_\_

Please include details of past relevant medical treatment, which substantiates need for exception to using formulary alternatives: (e.g. past prescription treatment failures, documented side effects, chart documentation, lab values, etc.):

Formulary Drug Tried/Previous Therapy (include strength, frequency, and duration, response, including adverse reaction)	Date(s) of Therapy	Reason for discontinuing therapy (e.g. adverse reactions, other...)

### Other Considerations

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

FOR INTERNAL USE ONLY						
Approved By: _____			Date: _____			
Denied By: _____			Date: _____			
Entered By: _____			Date: _____			
Physician Notified By: _____			Date: _____			
<b>TYPE OF REQUEST: (Circle One)</b>						
Prior auth	Non-Form	MRXC Rules	Edit Over	3 Day Supply	Non-Form B	OTC/RTS
Auth Start Date: _____			Auth End Date: _____			

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