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 UFT Welfare Fund  
 52 Broadway  
 New York, NY 10004

## UFT WELFARE FUND Mandatory Generic Price Waiver Form

### MEMBER INFORMATION - PLEASE PRINT

EMPLOYEE COMPLETES	MEMBER NAME		BIRTHDATE	SEX	SOCIAL SECURITY #	FILE NUMBER
	HOME ADDRESS		CITY	STATE	ZIP	TELEPHONE # ( )
	SCHOOL OR BUREAU	SCHOOL TELEPHONE #	Check Type of Medical Coverage You Have Selected			Are you covered by another Prescription Benefits plan?
	NAME OF OTHER COMPANY/ORGANIZATION PROVIDING BENEFITS		POLICY/PLAN NUMBER			
	<b>PATIENT INFORMATION - Required if claim is for Spouse/Domestic Partner or Child</b>					
	PATIENT NAME		BIRTHDATE	SOCIAL SECURITY #		
	RELATIONSHIP TO MEMBER <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child		FULL TIME COLLEGE STUDENT <input type="checkbox"/> Yes <input type="checkbox"/> No		Is patient covered by another Prescription Benefits plan? <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, Specify Below	
	NAME OF OTHER COMPANY/ORGANIZATION PROVIDING BENEFITS		POLICY/PLAN NUMBER			
	SIGNED (MEMBER)		DATE			

### TO BE COMPLETED BY PHYSICIAN FOR EVALUATION BY THE FUND'S MEDICAL ADVISOR (Please enclose any additional medical information you deem pertinent)

PHYSICIAN COMPLETES	PHYSICIAN NAME		TELEPHONE # ( )
	ADDRESS		CITY    STATE    ZIP
	PATIENT'S NAME (First, M.I., Last)		DATE FIRST CONSULTED
	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY FOR WHICH THE EXCEPTION IS REQUESTED		
	ANTICIPATED DURATION OF DRUG TREATMENT	BRAND NAME DRUG PRESCRIBED	GENERIC EQUIVALENT REQUESTED
	Have you tried a generic equivalent drug to treat <b>this condition for this patient?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when and for how long? _____ Describe this patient's reaction caused by use of the generic medication: _____ _____ Do you attribute this patient's reaction exclusively to the use of the generic drug? <input type="checkbox"/> Yes <input type="checkbox"/> No In your opinion, why do you believe the generic drug caused this reaction in this patient? _____ _____ If no, please explain why you would not prescribe a generic drug for this patient. (Include appropriate documentation) _____ _____ _____		
	In your opinion, could lack of effectiveness of the generic medication be considered extremely serious or life threatening for this patient? <input type="checkbox"/> Yes <input type="checkbox"/> No    Explain: _____ _____ _____		
	Physician's Signature		Date