



## Important Information about Prescription Drug Coverage

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To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

Re: Request for Quantity Limit Exception: Please Respond.

- Please complete the attached Request for Quantity Limit Exception Form.
- To prevent delays in the review process please complete all requested fields.
- Completed forms should be faxed to: 1-855-633-7673. It is not necessary to fax this cover page.

## Information about this Request for Quantity Limit Exception

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Use this form to request coverage of a quantity in excess of plan quantity limits. Quantity limits are in place on certain classes of agents based on manufacturer's safety and dosing guidelines. To process this request, documentation must be provided explaining why the quantity allowed would be ineffective or adversely affect the patient. Please provide clinical information or other evidence to support prescribing this medication in excess of plan quantity limits, including previous doses and other drugs attempted for this patient's condition.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

**Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.**

Advantage U is a PPO with a Medicare contract. Enrollment in Advantage U depends on contract renewal.

Member privacy is important to us. Our employees are trained regarding the appropriate way to handle our members' private health information.

**CONFIDENTIALITY NOTICE:** This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.



Request Expedited Review

Request for Quantity Limit Exception

Patient Information

Name:
Member ID:
Medicare ID:
Date of Birth:
Address:
City:
State:
Zip:
Phone:
Nursing Home Resident?
Home Care Patient?

Prescriber and Pharmacy Information

Name:
Specialty:
DEA:
NPI:
Address:
City:
State:
Zip:
Phone:
Fax:
Pharmacy Name:
NCPDP:
NPI:
Phone:
Fax:

All items below this line are for Physician Use Only

Information for Requested Drug

Drug Name:
Strength:
Dosage:
30 Day Qty.
Directions:
Drug Requested:
Brand / Generic
Drug:
Newly Prescribed / Refill
Diagnosis:

ICD-10 Code: Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review time frame will seriously jeopardize the health of your patient.

Request for Quantity Limit Exception Criteria

Medical Justification: Please provide medical justification for the quantity limit exception request. Attach additional pages if necessary.

- Has previously been ineffective in the treatment of the enrollee's disease or medical condition...
Based on both sound clinical evidence and medical and scientific evidence...
If no prior trial of the requested medication has been previously prescribed...

I attest that the information provided on this form is true and accurate as of this date.

Prescriber's Signature
Date: