Advantra® from Coventry Health Care

First Health® Part D from Coventry Health Care

QUANTITY LIMIT EXCEPTION REQUEST FORM

PLEASE FAX COMPLETED FORM TO: (800) 639-9158

******Please note any information that is incomplete or illegible will delay the review process.******

Patient Name:	**Member ID #**
****Member Phone Number****	
Date of Request:	**DOB:**
Plan ID:	**Benefit:**
Requesting Physician:	**DEA #**
Office Phone #	**Office Fax #**
Office Address:	
Tax ID Number:	

MEDICATION INFORMATION

1.	**Drug Requested:**
2.	**Dosing instructions and quantity requested per 30 days:**
3.	**Diagnosis:**
4.	**Length of treatment requested at this dose:**
5.	**List previous trials and failures:** **Drug: Date(s) used: Outcome:** **Drug: Date(s) used: Outcome:** **Drug: Date(s) used: Outcome:**
6.	**Other supporting information:**

For Urgent Requests please call (800) 551-2694

Visit our Websites at http://www.firsthealthpartd.com, http://www.chcadvantra.com, http://www.summithealthplan.com and http://www.vistahealthplan.com

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This section to be used only if requesting a quantity limit exception to the plan's established quantity limits.
Not completing below means medical exception to the formulary quantity limit is not needed.

☐ I have reviewed the formulary quantity limit requirements and acknowledge that the patient has not failed therapy within the quantity limits established by the plan. However, based upon the reason I will provide below, it is my clinical opinion that utilizing the medication within the quantity limits listed on the plan's formulary would not be as effective for the enrollee and/ or likely have adverse effects. **Statement should include specifically why member can not utilize treatment within our quantity limits.**

(Please note any information that is incomplete or illegible will delay the review process.)

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Physician's Signature:

CHCH 5117-5 (9/12)

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