

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.	<table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Drug:</td> <td style="width: 33%;">Date(s) used:</td> <td style="width: 33%;">Outcome:</td> </tr> <tr> <td>Drug:</td> <td>Date(s) used:</td> <td>Outcome:</td> </tr> <tr> <td>Drug:</td> <td>Date(s) used:</td> <td>Outcome:</td> </tr> </table>	Drug:	Date(s) used:	Outcome:	Drug:	Date(s) used:	Outcome:	Drug:	Date(s) used:	Outcome:
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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.)

Physician's Signature:

CHCH 5117-5 (9/12)

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