

Quantity Limit Request Form DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Pro	<b>Provider Information</b> (required)		
Member Name:			Provider Name	Provider Name:		
Insurance ID#:			NPI#:	NPI#: Specialty:		
Date of Birth:			Office Phone:	Office Phone:		
Street Address:			Office Fax:	Office Fax:		
City:	State:	Zip:	Office Street A	Office Street Address:		
Phone:	I	L	City:	State:	Zip:	
		Medication	Information (re	quired)		
Medication Name:			Strength:		Dosage Form:	
Check if requesting brand			Directions for	Directions for Use:		
Check if request is for continuation of therapy						
		<b>Clinical In</b>	formation (requi	ired)		
What is the patient	's diagnosis for	the medication bei	ng requested?			
			ICD-10 Code	ICD-10 Code(s):		
What is the quantity	requested per DA	Y?				
What is the reason	for exceeding th	e plan limitations?	?			
Titration or loading	ng dose purposes	-				
Patient is on a do bedtime)	ose-alternating scl	nedule (e.g., one tab	plet in the morning a	nd two tablets at	night, one to two tablets at	
Requested stren	ath/dose is not co	mmercially available	9			
Patient requires				a <b>[Topical appli</b>	cations only]	
Other:						
Are there any other cor to this review?	nments, diagnoses, s	symptoms, medications	s tried or failed, and/or a	any other informatio	n the physician feels is important	

Please note: This request may be denied unless all required information is received. For urgent or expedited requests please call 1-855-401-4262. This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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