

Medicare Part D Quantity Limit Exception Form



Instructions:

- Please fill out all applicable sections on both pages completely and legibly.
- Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the formulary exception request).
- Fax completed forms to (833) 434-0563.
- Information contained in this form is Protected Health Information under HIPAA.

Information about the Request for Coverage of a Non-Formulary Drug (Formulary Exception):

- Use this form to request coverage of a drug at a quantity exceeding the plan's quantity limits.
- To process this request, please provide documentation that explains why the quantity allowed on the formulary would be less effective or cause adverse effects for the member's condition.
- Please provide clinical information or other evidence supporting the medical necessity of covering the drug quantity exceeding the plan's quantity limits.

Medicare Part D Quantity Limit Exception Form

☐ STANDARD ☐ URGENT

Member Information

LAST NAME:

FIRST NAME:

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PHONE NUMBER:

DATE OF BIRTH:

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STREET ADDRESS :

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CITY :

STATE:

ZIP CODE:

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☐ MALE ☐ FEMALE HEIGHT (in/cm): WEIGHT (lb/kg): ALLERGIES:

Insurance Information

PRIMARY INSURANCE NAME:

PATIENT ID NUMBER:

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SECONDARY INSURANCE NAME:

PATIENT ID NUMBER:

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Prescriber Information

LAST NAME:

FIRST NAME:

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PRESCRIBER SPECIALTY:

E-MAIL ADDRESS:

NPI NUMBER:

DEA NUMBER:

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PHONE NUMBER:

FAX NUMBER:

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STREET ADDRESS:

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CITY:

STATE:

ZIP CODE:

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REQUESTOR (if different than Prescriber):

OFFICE CONTACT PERSON:

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Medicare Part D Quantity Limit Exception Form

MEMBER'S LAST NAME:

MEMBER'S FIRST NAME:

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Medication / Medical and Dispensing Information

Medication Name: ☐ Brand ☐ Generic *(Must Check one)*

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity & Day Supply:
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☐ New Therapy ☐ Renewal ☐

If Renewal: Date Therapy Initiated: _____ Duration of Therapy (specific dates): _____

How did the patient receive the medication?

☐ Paid under Insurance Name: _____ Prior Auth Number (if known): _____

☐ Other (explain): _____

Administration:

☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other: _____

Administration Location: ☐ Patient's Home ☐ Long Term Care

☐ Physician's Office ☐ Home Care Agency ☐ Other (explain): _____

☐ Ambulatory Infusion Center ☐ Outpatient Hospital Care _____

1. Has the patient tried any other medications for this condition? ☐ YES (if yes, complete below) ☐ NO

Medication/Therapy (Specify Drug Name and Dosage)	Duration of Therapy (Specify Dates)	Response/Reason for Failure/Allergy

2. List Diagnoses: _____ ICD-10: _____

3. REQUIRED CLINICAL INFORMATION – Please provide all relevant clinical information to support a quantity limit exception request review.

Please provide prior treatment failures of the requested drug at quantities available under the quantity limit; or any known relevant physical or mental characteristics of the member or the drug regimen that would be ineffective and/or affect patient compliance.

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

To submit a prior authorization request, please complete the Prescription Drug Prior Authorization Form and send it (along with additional documentation, if necessary) to any of the following:

Fax: (833) 434-0563
Electronic: CoverMyMeds® website
Mail: Judi Rx Attn: Claims Dept.
9450 SW Gemini Dr., #87234
Beaverton, OR 97008