

Quantity Limit Exception Request Form

To submit request electronically, please go to providerportal.surescripts.net/ProviderPortal/login **OR** covermymeds.com using Plan/PBM Name "BCBS NC"

Fax: <u>888-446-8535</u>

Mail: Blue Cross NC, ATTN: Part D Coverage Determination

P.O. Box 2251, Durham, NC 27702-2251

Call: 888-298-7552 Blue Medicare Rx

888-296-9790 Blue Medicare HMO/PPO

Incomplete Form May Delay Processing Prescriber Information Patient Information Physician Name: Patient Name: NPI#: Office Contact Person: Patient ID #: Office Phone #: Home Phone #: Office Fax #: Sex: ☐ Female ☐ Male Address: City: State: DOB: Zip: **Diagnosis and Medication Information** Diagnosis Code: Medication Requested: Strength and Route of Administration: Dosing Schedule: Quantity per 30 Days: Please answer questions below **NOTE:** Please refer to the patient's formulary for program quantity limits. Check the "Yes" box to request an expedited review if the enrollee or his/her physician or other prescriber believes that waiting for a decision under the standard time frame may place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. A standard review will have a decision made within 72 hours for a coverage determination. 2. Can the prescribed total daily dose be achieved with a lower quantity of a higher strength that does not exceed the quantity limit (e.g., one 60 mg tablet/day in place of two 30 mg tablets/day)?......

Yes
No 3. Please list the names AND strengths of all medications (including other strengths or doses of the requested medication) the patient has previously tried and failed, or had an inadequate response, related to this diagnosis: 4. Please provide clinical rationale in support of the quantity requested, including length of time the requested dose has been used (may submit medical records to support this request): 5. Is the requested medication an opioid?...... ☐ Yes ☐ No If YES, please answer the following questions: A. Is the patient currently (within the past 90 days) being treated with opioids?..... □ Yes □ No i. If NO, does the patient require more than a 7 days' supply of the requested medication?........... ☐ Yes ☐ No a. If YES, please provide a clinical rationale in support of an extended duration (beyond a 7 days' supply), including length of time the requested medication will be used (may submit medical records to support this request): PLEASE CONTINUE TO NEXT PAGE



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B. Is the patient currently being treated with a benzodiazepine at the same time as the requested medication? i. If YES, please provide a clinical rationale in support of the concurrent use of a benzodiazepine with the requested medication:		□ No
6. Is the request for formulary diabetic test strips (Ascensia Contour or OneTouch)?	□ Voc	ПМо
A. Is the quantity requested greater than the set quantity limit of #204 test strips per 30 days?	. □ Yes	□ No
i. If YES , does the patient use an insulin pump?		⊔No
ii. If YES to 6A. , please provide a clinical rationale in support of the quantity requested, including how often the patient is testing their blood sugar (may submit medical records to support this request):		
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I certify that I have appropriate authority to request a coverage determination for the medication indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information.		
Physician Signature: Date:		