BlueCross BlueShield of North Carolina

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: 888-446-8535

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:	NPI #:	Patient Name:
Office Contact Person:		Patient ID #:
Office Phone #:	Office Fax #:	Home Phone #:
Address:		Sex: ☐ Female ☐ Male
City: State: Zip:		DOB:

Diagnosis and Medication Information	
Medication Requested:	Diagnosis Code:
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.

1. Is this request for an expedited review?..... ☐ Yes ☐ No
   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): _____
   _____
   _____

PLEASE CONTINUE TO NEXT PAGE

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5. Is the requested medication an opioid? ☐ Yes ☐ No
   A. **If YES,** 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
         If YES, please answer the following questions:
         a. Is the requested medication being used to treat cancer-related pain? ☐ Yes ☐ No
         b. Is the requested medication being used to treat sickle cell disease-related pain? ☐ Yes ☐ No
         c. Does the patient reside in a long-term care facility? ☐ Yes ☐ No
         d. Is the patient in hospice or receiving palliative or end-of-life care? ☐ Yes ☐ No
            1. **If NO**, 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):
               _____
               _____
               _____

   B. Is the patient currently being treated with a benzodiazepine at the same time as the requested medication? ☐ Yes ☐ No
      i. **If YES**, please provide a clinical rationale in support of the concurrent use of a benzodiazepine with the requested medication:_____
      _____
      _____

6. Is the request for formulary diabetic test strips (Ascensia Contour or OneTouch)? ☐ Yes ☐ No
   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? ☐ Yes ☐ No
         a. **If YES,** please specify the particular product (such as Omnipod, Medtronic): _____
         _____
         _____
      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): _____
      _____

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: _____

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