Quantity Limit Exception Form
Fax 1-866-423-0945
Pharmacy Dept. Phone 401-427-8200

This form is to be used by participating physicians and providers to obtain coverage. Please complete the form by providing all of the following information. Fax the completed form to Neighborhood at **1-866-423-0945**. For real time Coverage Determination decisions, please go to Cover My Meds: https://www.covermymeds.com/epa/caremark/.

Quantity Limit Exception Prior Authorization Form

Enrollee's Name		Date of Birth
Enrollee's Address		
City	State	Zip Code
Phone	Enrollee's Member ID #	

Important Note: Expedited Decisions
If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. ☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 24 HOURS**

Prescriber's Information		
Name and NPI		
Address		
City	State	Zip Code
Office Phone	Fax	
Prescriber's Signature		Date

Diagnosis and Medical Information			
Medication:	Strength and Route of Administration:		Frequency:
New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:		Quantity:
Height/Weight:	Drug Allergies:	Diagnosis:	

Criteria Questions			
1	Is the requested drug/product being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? [Documentation of diagnosis required]	Yes	No
2	Does the prescribed dose and quantity fall within the FDA-approved labeling or dosing guidelines found in the compendia of current literatura? Please indicate dose requested (i.e. directions of use) for review of a quantity limit exception: _____	Yes	No
3	Is this a request for continuation of therapy on the requested dose where patient is stable and not experiencing any adverse side effects? If yes, please provide start date of therapy on requested dose: _____	Yes	No
4	Has the patient tried and failed lower doses of the requested medication? If yes, please provide the previously failed regimens: _____ _____ _____	Yes	No

After filling out the questionnaire, if there is any additional clinical information that you would like to provide, please indicate below.

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I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's Signature _____ NPI _____ Date _____