

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>

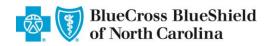
Mail: Blue Cross NC, ATTN: Part D Coverage Determination

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

Call: 888-298-7552 Blue Medicare Rx

888-296-9790 Blue Medicare HMO/PPO

		mplete Form May Dela			
Prescr	iber Information		Patient Information		
Physician Name:	NPI #	t: Pati	ent Name:		
Office Contact Person:			ent ID #:		
Office Phone #: Office Fax #:		Hon	ne Phone #:		
Address:		Sex	□ Female □ Male		
City:	State: Zip	: DOE	3:		
	Diag	nosis and Medicatio			
Medication Requested:		Diag	nosis Code:		
Strength and Route of Administration:			ing Schedule:		
Quantity per 30 Days:					
	P	lease answer questi	ons below		
NOTE: Please refer to the					
believes that waiting a ability to regain maxin hours for a coverage decay. 2. Can the prescribed total exceed the quantity linuary. 3. Please list the names a requested medication.	for a decision under num function in ser etermination. al daily dose be ac mit (e.g., one 60 mo	the standard time frame ious jeopardy. A standard nieved with a lower qua g tablet/day in place of t	e or his/her physician or other prescriber amay place the enrollee's life, health, or d review will have a decision made within 72 mitty of a higher strength that does not wo 30 mg tablets/day)?	□ Yes	□ No
			ted, including length of time the support this request):		
If YES, please answ A. Is the patient cu i. If NO, does th a. If YES 7 day	er the following que rrently (within the p ne patient require r s, please provide a s' supply), includin	estions: ast 90 days) being trea nore than a 7 days' sup clinical rationale in sup _l g length of time the requ	ted with opioids? oly of the requested medication? port of an extended duration (beyond a uested medication will be used (may	□ Yes	□ No
	Pi	LEASE 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. In the request for formulary dishetic test strips (Assensis Centeur or One-Tough)?	□ Voo	ПМо	
6. Is the request for formulary diabetic test strips (Ascensia Contour or OneTouch)?			
i. If YES, does the patient use an insulin pump?		□ 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 of I further certify that the patient's medical records accurately reflect the information provided. I understand the NC may request medical records for this patient at any time in order to verify this information.			
Physician Signature: Date:			