TexanPlus® HMO/HMO-POS

A WellCare Company

Fax completed form to: **1-855-714-6218**
Questions, please call: **1-866-230-2513**
8:00 am. to 8:00 p.m. in your local time zone, 7 days a week
TTY users call: **711**

Important Information about Prescription Drug Coverage

To: _____ From: _____

Fax:_____ Pages:_____

Re: Request for Quantity Limit Exception: Please respond.

- Please complete the attached Request for Quantity Limit Exception Form.
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: **1-855-714-6218**. It is not necessary to fax this cover page.

Information about this Request for Quantity Limit Exception

Use this form to request coverage of a quantity in excess of plan quantity limits. Quantity limits are in place on certain classes of agents based on manufacturer's safety and dosing guidelines. To process this request, documentation must be provided explaining why the quantity allowed would be ineffective or adversely affect the patient. Please provide clinical information or other evidence to support prescribing this medication in excess of plan quantity limits, including previous doses and other drugs attempted for this patient's condition.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

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Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

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Request for Quantity Limit Exception (2018)

Patient Information

Name: _____
Member ID: |_|_|_|_|_|_|_|_|_|_|_|_|
Medicare ID: |_|_|_|_|_|_|_|_|_|_|_|_|
Date of Birth: _____ Sex: ☐ M ☐ F
Address: _____
City: _____
State: _____ Zip: _____
Phone: _____
Nursing Home Resident? ☐ YES ☐ NO
Home care patient? ☐ YES ☐ NO

Prescriber and Pharmacy Information

Name: _____
Specialty: _____
DEA: |_|_|_|_|_|_|_|_|_|_|_|_|
NPI: |_|_|_|_|_|_|_|_|_|_|
Address: _____
City: _____
State: _____ Zip: _____
Phone: _____ Fax: _____
Pharmacy Name: _____
NCPDP: |_|_|_|_|_|_|_|
NPI: |_|_|_|_|_|_|_|_|_|_|
Phone: _____ Fax: _____

All items below this line are for Physician Use Only

Information for Requested Drug

Drug Name: _____ Drug Requested is (check one): ☐ Brand ☐ Generic
Strength: _____ Dosage form: _____ Qty per 30 days: _____
Drug is (check one): ☐ Newly prescribed ☐ Refill Directions: _____
Diagnosis _____ ICD-10 Code: _____

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review time frame will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Request for Quantity Limit Exception Criteria

Medical Justification: Please provide medical justification for the quantity limit exception request. Attach additional pages if necessary. If the number of doses available under a dose restriction for the prescription drug:

☐ Has previously been ineffective in the treatment of the enrollee's disease or medical condition, please specify relevant prior treatment experience here:

_____
_____
_____

☐ Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance, please specify relevant clinical concerns here:

_____
_____
_____

☐ If no prior trial of the requested medication has been previously prescribed in quantities available under the quantity limit, please check this box.

I attest that the information provided on this form is true and accurate as of this date:

Prescriber's Signature: _____ **Date:** _____