

Fax completed form to: 1-866-868-0858  
Questions, please call: 1-866-316-6049

**Avera Advantage**<sup>™</sup>

**Important Information About Prescription Drug Coverage**

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To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

Re: Request for Quantity Limit Exception: Please respond.

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- 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: 1-866-868-0858. It is not necessary to fax this cover page.

**Please note:** By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

**Information about this Request for Quantity Limit Exception**

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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.

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

# Request for Quantity Limit Exception

**Avera Advantage™**

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## 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: \_\_\_\_\_

Strength: \_\_\_\_\_ Dosage form: \_\_\_\_\_ Qty per 30 days: \_\_\_\_\_ Drug is (circle one): Newly prescribed/Refill

Directions: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe 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

- Please provide medical justification for quantity limit exception:
  - Supporting documentation must be provided demonstrating at least one of the following (check applicable statements and provide justification):
    - The number of doses available under the quantity limit restriction has been ineffective in the treatment of the patient's disease or medical condition.
    - Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the patient, and known characteristics of the drug regimen, the number of doses available is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

**Medical Justification:** Provide clinical information or other evidence to support medical necessity for this request. List previous drugs and doses attempted for this patient, condition and dates or approximate dates or duration of treatment (if known). Document adverse effects requiring discontinuation and/or reason for perceived ineffectiveness. Attach additional pages if necessary. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DRUG NAME & DOSE	REASON FOR D/C	DURATION OF THERAPY

Prescriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_