

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



Important Information About Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

Re: Seroquel® (quetiapine): Quantity Limit Exception Form: Please respond.

- Please complete the attached Seroquel® (quetiapine) 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 drug

Seroquel® (quetiapine)

The recommended maximum dose from the package labeling for quetiapine is 800 mg/day; however, evidence supporting higher doses in treatment-resistant patients have been published. Expert consensus statements from the J Clin Psychiatry recommend the highest acute treatment dose be limited to 950 mg/day, while the target dose in treatment-resistant patients can be up to 1100 mg/day. Our quantity limits allow for 1200mg/day.

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.

Quantity Limit Exception Form

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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

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.

Seroquel® (quetiapine) Criteria

- 1 Please indicate product requested:
 Seroquel® tabs Seroquel XR®
- 2 Please specify indication for Seroquel® use:
 Schizophrenia or other chronic psychotic disorders
 Bipolar Disorder
 Behavioral disturbances in the elderly that impair functional ability
 Other
- 3 Is the patient currently taking Seroquel?
 Yes No
- 4 Please specify the diagnosis code(s) supporting the necessity for the requested agent. This question must be completed.
 ICD-9:
- 5 Is the patient greater than or equal to 65 years old?
 Yes No
 If the answer to question #3 was yes, then answer the following:
- 6 How long has the current dose been used?
 > 1 month < 1 month
- 7 Is the patient compliant to the medication regimen (taken 95% of doses in last 30 days)?
 Yes No
- 8 Please indicate which of the following best describes your patient's antipsychotic regimen:
 The patient is receiving an enzyme inducer (e.g., carbamazepine).
 The patient received a partial response and is tolerating the current dose.
 The patient receiving more than one atypical antipsychotic agent and is not in the process of dosage cross titration.
 A lipid panel, fasting glucose, weight, BMI, and BP should be evaluated prior to initiation & periodically thereafter.

Medical justification: (Attach additional page if necessary): _____

Prescriber's signature: _____ Date: _____