BlueCross BlueShield of North Carolina

# Quantity Limit Exception Request Form

To submit request electronically, please go to covermymeds.com using Plan/PBM Name "BCBS NC"

Fax: 888-446-8535

Mail: Blue Cross NC, ATTN: Part D Coverage Determination
P.O. Box 17509, Winston Salem, NC 27116-7509

Call: 888-298-7552 Blue Medicare Rx
888-296-9790 Blue Medicare HMO/PPO

**Incomplete Form May Delay Processing**

| Prescriber Information | | Patient Information |
|---|---|---|
| Physician Name: | NPI #: | Patient Name: |
| Office Contact Person: | | Patient ID #: |
| Office Phone #: | Office Fax #: | Home Phone #: |
| Address: | | Sex: ☐ Female ☐ Male |
| City: State: Zip: | | DOB: |

| Diagnosis and Medication Information | |
|---|---|
| Drug Requested: | Diagnosis Code: |
| Strength and Route of Administration: | Dosing Schedule: |
| Quantity per 30 Days: | |

## Please answer questions below

**NOTE:** Please refer to the patient's formulary for program quantity limits.

1. Is this request for an expedited review? ☐ Yes ☐ No
   ***Check the "Yes" box to request an expedited review if the enrollee or his/her physician or other prescriber believes that waiting for a decision under the standard time frame may place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.*** *A standard review will have a decision made within 72 hours for a coverage determination.*
2. Can the prescribed total daily dose be achieved with a lower quantity of a higher strength that does not exceed the quantity limit (e.g., one 60 mg tablet/day in place of two 30 mg tablets/day)? ☐ Yes ☐ No
3. Please list the names **AND** strengths of all medications (including other strengths or doses of the requested medication) the patient has previously tried and failed, or had an inadequate response, related to this diagnosis: _____
   _____
4. Please provide clinical rationale in support of the quantity requested, including length of time the requested dose has been used (may submit medical records to support this request): _____
   _____
   _____
5. Is the requested medication an opioid? ☐ Yes ☐ No
   A. **If YES to 5.,** is the patient enrolled in a hospice program OR has a life expectancy of less than 6 months? ☐ Yes ☐ No
      i. **If NO to 5.A.,** please describe the plan for monitoring this patient's opioid treatment (office visits, pill counts, urine drug screens, etc.): _____
      _____

I certify that I have appropriate authority to request a coverage determination for the medication indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information.

Physician Signature:_____ Date: _____



Updated: 01/01/2022