PRIOR AUTHORIZATION REQUEST
Global Quantity Limit

PATIENT: Name_____
Address:_____
City, State, Zip_____
D.O.B._____
Member ID: _____

Prescriber: Name_____
Address_____
City, State, Zip_____
Phone _____
Fax_____
NPI _____

Medication Requested: _____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A Please answer the following questions

1. Please document the diagnosis or indication AND the quantity for the requested medication per 12 months.
   _____
2. Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?
   - θ INITIAL
   - θ CONTINUATION → ***please answer questions 3 – 4 only***
3. θ Yes θ No Has the patient been compliant with the treatment regimen?
4. θ Yes θ No Has the patient had a response to treatment?
5. Is this request for quantities that EXCEED the maximum dose established by the FDA for the requested medication?
   - θ Yes → ***please answer question 6 – 9 only***
   - θ No → ***please proceed to question 10***
6. θ Yes θ No Did the patient have an inadequate response to the same medication at a LOWER dosage?
7. θ Yes θ No Was medication non-adherence ruled out as a reason for the inadequate response?
8. θ Yes θ No Is the patient tolerating the medication at a lower dosage?
9. θ Yes θ No Is there documentation of a peer-reviewed journal article that demonstrates the safety and efficacy of the requested dose for the indication?
10. Is this request for quantities of a LOWER strength that DO NOT EXCEED the maximum dose established by the FDA for the requested medication (for example, two 30mg tablets/day in place of one 60mg tablet/day)?
    - θ Yes → ***please answer question 11 – 14 only***
    - θ No → ***please proceed to question 15***
11. θ Yes θ No Is the dosing due to inadequate response to the optimized dose?
12. θ Yes θ No Is the dosing due to patient inability to tolerate total daily dose in one administration?
13. θ Yes θ No Is the dosing based on inability to swallow optimal dose?
14. θ Yes θ No Is there a manufacturer shortage on the optimized strength?
15. θ Yes θ No Is this request for quantities for a medication that does NOT have a maximum dose as established by the FDA?
16. θ Yes θ No Did the patient have an inadequate response to the SAME medication at a LOWER dosage?
17. θ Yes θ No Is the patient tolerating the medication at a LOWER dosage?
18. θ Yes θ No Is the requested dose considered medically necessary?

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If you have any questions, call: 800-753-2851

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Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-877-251-5896

If you have any questions, call: 800-753-2851