



## 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?  
 INITIAL  
 CONTINUATION → *please answer questions 3 – 4 only*
3.  Yes  No Has the patient been compliant with the treatment regimen?
4.  Yes  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?  
 Yes → *please answer question 6 – 9 only*  
 No → *please proceed to question 10*
6.  Yes  No Did the patient have an inadequate response to the same medication at a LOWER dosage?
7.  Yes  No Was medication non-adherence ruled out as a reason for the inadequate response?
8.  Yes  No Is the patient tolerating the medication at a lower dosage?
9.  Yes  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)?  
 Yes → *please answer question 11 – 14 only*  
 No → *please proceed to question 15*
11.  Yes  No Is the dosing due to inadequate response to the optimized dose?
12.  Yes  No Is the dosing due to patient inability to tolerate total daily dose in one administration?
13.  Yes  No Is the dosing based on inability to swallow optimal dose?
14.  Yes  No Is there a manufacturer shortage on the optimized strength?
15.  Yes  No Is this request for quantities for a medication that does NOT have a maximum dose as established by the FDA?
16.  Yes  No Did the patient have an inadequate response to the SAME medication at a LOWER dosage?
17.  Yes  No Is the patient tolerating the medication at a LOWER dosage?
18.  Yes  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:

Two horizontal lines for documentation.

SECTION B Physician Signature

PHYSICIAN SIGNATURE

DATE

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

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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