COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Quantity Limit Exception (QLE) Medicare

Phone: 833-697-6561 Fax back to: 877-503-7231

MedImpact manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Please note that MedImpact will process the request as written, including drug name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:

Q4. What is the quantity of medication that is being requested per 30 days? (If the request is for less than a 30-day supply, please provide the quantity requested and days' supply along with directions for use.)

Q5. The plan has set a quantity limit on this medication. In order to receive a quantity limit exception, please provide information regarding WHY the patient requires a greater quantity than that set by the plan.

COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Quantity Limit Exception (QLE) Medicare

Phone: 833-697-6561 Fax back to: 877-503-7231

MedImpact manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**

Q6. If the dose can be consolidated using a higher strength commercially available product, please provide details why this is not appropriate for this patient:

Prescriber Signature

Date