SENTARA COMMUNITY PLAN
(MEDICAID)

QUANTITY LIMIT EXCEPTIONS REQUEST

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

This form is intended for use when a formulary medication is being requested above the Health Plan quantity limit and/or FDA approved dosing. If the requested medication is Non-Formulary or is being requested for an off-label indication, please complete and submit the following form: Medicaid-NonPreferred-Drug-Medical-Necessity-Form.pdf

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

❑ **Newly Prescribed Therapy** **OR** ❑ **Continuation of Therapy**

Anticipated duration of therapy: _____ **Quantity per 30 Day Supply**: _____

Diagnosis for this Drug or ICD Code: _____

If diagnosis is pain, is this cancer pain? _____

NOTE: Select non-specialty and specialty medications are limited to a 34-day supply

❑ Requested dose exceeds at least **ONE** of the following **(check all that apply)**:
- ❑ Maximum FDA approved labeling for the requested indication
- ❑ Sentara Health Plans allowable quantity limit
- ❑ Other: _____

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- ❑ Provider must submit documentation for each of the following, **IF applicable**:
  - ❑ Provider has submitted documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature) **(attach additional pages if necessary)**
  - ❑ Member has tried and failed all available alternative dosage strength(s) for the requested drug that can be obtained within the SHP allowable quantity limits unless no alternative dosage strength is available **(submit documentation of treatment failure)**
  - ❑ Member has tried and failed FDA approved dose and/or frequency for the requested indication **(submit documentation of treatment failure)**

    [**EXAMPLE:** The requested dosing regimen (Trintellix 5 mg tablet taken daily along with Trintellix 10 mg tablet) is not covered by the plan. The plan covers Trintellix 10 mg tablet taken as 1 tablet daily or Trintellix 20 mg tablet taken as 1 tablet daily. According to the Trintellix prescribing information, the recommended starting dose is 10 mg administered orally once daily without regard to meals. The dose should then be increased to 20 mg/day, as tolerated. Provider must submit documentation that the member has had an unsuccessful trial of Trintellix 20 mg taken once daily.]
- ❑ Provider must document all applicable previously failed therapies for requested indication:
  _____
- ❑ Provider must submit clinical rationale for the requested quantity exceeding plan limits **(attach additional pages if necessary)**

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Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.