COVERAGE DETERMINATION REQUEST FORM

Quantity Limit Exception

Phone: 833-320-1824 Fax back to: 866-351-1617

SlateRx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions, sign 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:	

☐ Standard ☐ Expedited / Urgent

Drug Name and Strength:

Directions / SIG:

Q1. Please indicate the patient's diagnosis for the requested medication.

Q2. Is the request for initial or continuing therapy? (If continuation of therapy, please include the start date - MM/YYYY)

☐ Initial therapy ☐ Continuing therapy _____

Q3. Please provide the quantity of medication requested per 30 days. (If the request is for less than a 30 day supply, please provide the quantity and day supply being requested along with the directions.)

Q4. Please provide rationale as to why the patient requires more than the plan's quantity limit for the medication. (If the quantity is higher than the max FDA dosing, please provide a peer-reviewed journal article to support the high dosing.)

Prescriber Signature: _____ Date: _____