

Prior Authorization Request



EOC: Quantity Limit Override Form

Serve You Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Fill out electronically, or print using blue or black ink. If you have questions or need additional forms, visit [ServeYouRx.com](https://www.ServeYouRx.com) or call 800-759-3203.

Fax completed form to: 800-480-4840, Attn: Authorizations **Note:** Blank fields or illegible responses may delay the review process.

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____
Date of Birth: _____ Member ID #: _____ Group #: _____
Permanent Address: _____ City: _____ State: _____ ZIP: _____
Primary Phone #: _____ Secondary Phone #: _____
 Mobile Work Home Mobile Work Home

PRESCRIBER INFORMATION

Name: _____ Specialty: _____
Address: _____ City: _____ State: _____ ZIP: _____
NPI: _____ State License ID: _____
Office Contact: _____ Fax: _____ Phone: _____

REQUESTED MEDICATION

Drug Name: _____ Strength: _____ Frequency: _____
Directions: _____
Expected Duration of Therapy: _____ If this is a continuation of therapy, provide start date: _____
 Pertinent medical history or information for this patient is attached that may support approval
 Urgent review requested

REQUIRED INFORMATION

<p>1 Is the dose requested for titration or loading-dose purposes? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>8 Are higher doses supported by published study data or treatment guidelines? (please provide literature citations) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>2 Is the requested strength/dose commercially available? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>9 Additional Comments:</p>
<p>3 Is the patient on a dose alternating schedule? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>4 For topical applications, does the patient require a larger quantity to cover a larger surface area? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>5 Have lower doses been tried for an adequate period of time and have been deemed ineffective? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>6 Has the patient tried and failed previous therapies at FDA-approved dosing for the condition being treated? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>7 If yes to above: Please indicate which medications the patient has tried and failed:</p>	

Prescriber Signature _____
Date

Certain prescription benefit plans or situations may require additional information or clarification to evaluate a prior authorization request. For complete details about benefits, limitations, conditions and exclusions, please refer to the applicable plan. The information contained in this document may be confidential, is intended only for the use of the recipient(s) named above, and may be legally privileged. If you are not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this document, or any of its contents, is strictly prohibited. If you have received this document in error, please notify the sender immediately and arrange for the return or destruction of the document. For questions, please contact the sender.