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 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 #: _____ ☐ Mobile ☐ Work ☐ Home

Secondary Phone #: _____ ☐ 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

1 Is the dose requested for titration or loading-dose purposes?
☐ Yes ☐ No

2 Is the requested strength/dose commercially available?
☐ Yes ☐ No

3 Is the patient on a dose alternating schedule?
☐ Yes ☐ No

4 For topical applications, does the patient require a larger quantity to cover a larger surface area?
☐ Yes ☐ No

5 Have lower doses been tried for an adequate period of time and have been deemed ineffective?
☐ Yes ☐ No

6 Has the patient tried and failed previous therapies at FDA-approved dosing for the condition being treated?
☐ Yes ☐ No

7 **If yes to above:** Please indicate which medications the patient has tried and failed:

8 Are higher doses supported by published study data or treatment guidelines? (please provide literature citations)
☐ Yes ☐ No

9 Additional Comments:

_____ _____
Prescriber Signature Date