COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Elixir Quantity Limit Exception (QLE)

Phone: 800-361-4542 Fax back to: 866-414-3453

Elixir 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 Elixir 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:
Q3. Please provide the patient's diagnosis for the requested medication below:
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 day supply along with the directions for use)?
Q5. This 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:
Q6. If the dose can be consolidated using a higher strength commercially available product, please explain why this is not appropriate for the patient.

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Patient Name:	**Prescriber Name:**

Prescriber Signature

Date