



Physician's Quantity Limit Questionnaire

Patient:

ID#:

DOB:

Patient Address:

This medication is limited to specific quantity amounts per prescription fill as listed below. Please provide all the information below to assist us in making a determination of coverage above the current quantity limits.

Drug Requested	Strength	Current Quantity Limits	Quantity Requested
		per day	

1. What is the patient's diagnosis? (No codes please.) _____

2. Reason for requesting quantity above: _____

3. What is the prescribed daily dosing schedule? (e.g., QAM, QHS, BiD, TiD...) _____

Physician's Signature

Date

Please Print Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.