QUANTITY LIMIT EXCEPTION REQUEST FORM

PLEASE FAX COMPLETED FORM TO: (800) 639-9158

Patient Name:	Member ID #
Date of Request:	DOB:
Requesting Physician:	DEA #
Office Phone #	Office Fax #

MEDICATION INFORMATION

1.	Drug Requested:
2.	Dosing instructions and quantity requested per 30 days:
3.	Diagnosis:
4.	Length of treatment requested at this dose:
5.	List previous trials and failures: Drug: Date(s) used: Outcome: Drug: Date(s) used: Outcome: Drug: Date(s) used: Outcome:
6.	Other supporting information:
Physician's Signature:	

CHCH 5117-5(11/07)

For Urgent Requests please call (800) 551-2694
Visit our Websites at www.advantrarx.com and www.firsthealthpartd.com

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