Mail Requests To: Cigna
8455 University Place # HQ2L-04
St. Louis, MO 63121
Fax Requests To: (866) 845-7267
Request By Phone: (877) 813-5595

Quantity Limit Exceeded Coverage Determination

(FOR PROVIDER USE ONLY)

MEMBER INFORMATION REQUIRED (Please Write Legibly)	
Customer Name:	Customer ID:
Customer DOB:	Customer Address:
Phone (Home):	Phone (Cell):

PROVIDER INFORMATION REQUIRED (Please Write Legibly)		
License Number:	DEA Number:	NPI Number:
Provider Name:	Provider Address:	
Provider Phone:	Provider Fax:	
Provider Specialty:	Office Contact Name:	

DRUG & PRESCRIPTION INFORMATION REQUIRED (Please Write Legibly)

Drug Name: _____ Dosage: _____

Frequency: _____ Quantity: _____ Days Supply: _____ Refills: _____

☐ ***Do Not Substitute-Dispense As Written***

Please check whether this is a new medication or therapy continuation

☐ **New Medication** ☐ **Continuation**

If you have checked "Continuation",
Provide Start Date---------> _____

DIAGNOSIS INFORMATION (Please Write Legibly)

List Diagnosis/ICD-10 Code(s): _____

Mail Requests To: Cigna
8455 University Place # HQ2L-04
St. Louis, MO 63121
Fax Requests To: (866) 845-7267
Request By Phone: (877) 813-5595

Quantity Limit Exceeded Coverage Determination

(FOR PROVIDER USE ONLY)

ATTENTION: FAILURE TO PROVIDE CLINICAL INFORMATION SUPPORTING RATIONALE MAY RESULT IN THIS REQUEST BEING DENIED, OR AN ADDITIONAL OUTREACH TO OBTAIN MISSING CLINICAL INFORMATION.

Other Questions:

Is the request for an inpatient that is awaiting discharge? ☐ YES ☐ NO

Has the patient tried and failed a lower dose (please document below)? ☐ YES ☐ NO

If lower dosing was not tried, please provide clinical explanation as to why dosing within the quantity limit would be ineffective, cause adverse effect or negatively impact medication compliance.

If the request is for an opioid prescription, please answer the following questions:

Has the customer had an opioid prescription within the last 120 days? ☐ YES ☐ NO

If greater than 7 days supply is requested, does the prescriber acknowledge that the requested dose which exceeds CMS threshold of 7 days' supply is medically necessary ? ☐ YES ☐ NO

Is the customer receiving opioids from another prescriber? ☐ YES ☐ NO

Is there a coordination of care between all opioid prescribers? ☐ YES ☐ NO

Is the requested dose (in combination with all other opioids) exceeding the CMS threshold of Morphine Milligram Equivalent (MME) of 90 mg/day? ☐ YES ☐ NO

If yes, does the prescriber acknowledge that the requested dose which exceeds CMS threshold of Morphine Milligram Equivalent (MME) of 90 mg/day is medically necessary ? ☐ YES ☐ NO

Is the customer resident of a long-term care facility, in hospice or receiving palliative care, or being treated for active cancer-related pain? ☐ YES ☐ NO

If the customer is unable to meet the criteria required for the requested medication, please provide a clinical explanation as to why an exception should be made:

☐ ***Request for expedited review [24 hours]. By checking this box, I certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the Customer or the Customer's ability to regain maximum function***

Provider Signature: **Date:**