ProCare Rx

Quantity Override Request

Ticket #: _____ **Request Date:** _____ **Request Time:** _____

PHYSICIAN CERTIFICATION QUANITITY OVERRIDE REQUEST FORM

Please fill out the following information and return to us as indicated below.

A. Member Information			
Patient Name:	Plan Name/Plan ID:		
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:	

B. Physician Information			
Physician Name:	Physician Address:		
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG): ----- SEE BELOW -----	QTY and Days Supply: ----- SEE BELOW -----	NDC #:

C. Pharmacy Information			
Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:

D. Clinical Information (Please fill out the following clinical information.)	
Diagnosis/Indication:	ICD-9 Code: (if available)

1. Medical justification for Quantity Override Request:
   - ☐ The medication is medically necessary for this patient
   - ☐ Formulary options would be hazardous to use
   - ☐ Formulary options have been tried and have caused undesirable side effects or have been insufficiently effective
2. Dosing instructions per 30-day supply: _____
3. Length of treatment requested at this does: _____
4. Please list other medications attempted for this patient:

   Medication: _____ Reason therapy failed: _____

   Medication: _____ Reason therapy failed: _____

   Medication: _____ Reason therapy failed: _____

Authorized Medical Signature:	
Telephone:	**Date:**

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes. *Revised 4/2015*