

### 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.