

**Blue Cross and Blue Shield of Vermont and The Vermont Health Plan
Prior Approval Form
Quantity Limit Authorization
BCBSVT and TVHP Fax # (802) 371-3491**

Please use this form to request dosage quantities above standardized limits for all drugs with quantity limits (Advair, Anzmet, Arixtra, Diflucan/Fluconazole, Dolasetron, Duragesic, Emend, Epipen, Fragmin, Inhalers, Innohep, Januvia, Kytril, Lovenox, Lyrica, Ondansetron, Narcotic Analgesics contain Acetaminophen 325mg/500mg, Pulmicort Respules, Sedative Hypnotics, Stadol Nasal Spray, Toradol, Diabetic Test Strips, Zofran).

DO NOT use this form for the following: Amerge, Axert, Frova, Imitrex, Maxalt, Oxycontin, Relpax, and Zomig as there is a specific form for these.

When criteria are met BCBSVT/TVHP will authorize coverage of quantities exceeding limit.

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request ____/____/____ Patient Name: _____
 Member ID#: _____ DOB: _____
 Provider Name: _____ Provider address: _____
 Provider Phone number: _____ Provider Fax number: _____

1. Drug requested: _____
2. Related diagnosis for the drug requested: _____
3. Quantity requested: _____ for a 30-day supply.
4. Rationale for quantity above BCBSVT limit: _____ _____ _____ _____

PRESCRIBER SIGNATURE _____ DATE _____
By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.

