Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Medication Request Form (MRF) –Commercial

Quantity Limit Request

This form is to be used by participating physicians to obtain coverage for **Quantity Limit requests.** Please complete this form and fax to the Pharmacy Services Clinical Help Desk at **(866) 601-4425** for BCBSM members or **(877) 442-3778** for BCN members. If you have any questions regarding this process, please contact BCBSM/BCN at (800) 437-3803.

Important information about Blue Cross and Blue Care Network plan approved quantity limits:
BCBSM/BCN Standard/Custom Select Plan Limits:
https://www.bcbsm.com/content/dam/public/Consumer/Documents/help/documents-forms/pharmacy/quantity-limit-program-drug-list.pdf

Step 1: Patient & Physician Info

Patient Information		Physician Information	
Name:		**Name:**	
ID Number:		**Specialty:**	
Date of Birth:		**DEA/NPI#:**	
Gender:	☐ Male ☐ Female	**Phone:**	
Phone:		**Fax:**	

Drug Name:		**Strength:**	
Sig:		**Duration:**	
Diagnosis:		**Quantity:**	

Step 2: Documentation to be included

For Quantity Limit Requests
Quantity limit requests require documentation to support dosing above the maximum FDA recommended dose and/or for quantities exceeding plan approved quantity limits.
Supporting documentation includes but is not limited to the following: Peer reviewed articles, Chart Notes, and Case studies

Step 3: Please answer the following questions

What is the patient's indication for this medication? _____

What are the directions for the **REQUESTED** dosage? _____

Quantity requested per 30 days: _____

Is the patient currently stable on this dosage? ☐ Yes ☐ No Start date for this dosing: _____

Has a FDA approved dosing been attempted? ☐ Yes ☐ No Dates of prior dosing:_____

Dosing: _____

Has supporting documentation from **Step 2** been included with this request? ***(This is required)***
☐ YES ☐ NO

*Please list **ANY OTHER** medications that have been tried & failed for this diagnosis.*
List the dates of therapy and the dosing.

Medication	Dates of therapy	Outcome

Prescriber's Signature:

Blue Cross Blue Shield of Michigan Prior Authorization Dept. PO Box 2320, Detroit, MI 48231-2320	**Phone: (800) 437-3803** **BCBSM Fax: (866) 601-4425** **BCN Fax: 877-442-3778**	Office Contact: Tech/Date/Time:

☐ Request for expedited review

By checking this box, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

See 29 CFR 2560.503-1 paragraph (m)(1)(i)(A) and (B) for the Department of Labor definition of an urgent request. Requests not meeting this definition will be determined according to the standard timeframes.

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