Maryland Medicaid Pharmacy Program
Quantity Limit Override Request Form
**Find Limits at www.epocrates.com
or www.maryland.gov/mma/mpap**

34141

Request Date

☐☐ / ☐☐ / ☐☐☐☐

Incomplete Forms May Delay Processing

PATIENT INFORMATION

Patient's Medicaid ID Number

☐☐☐☐☐☐☐☐☐☐☐

Patient's Date of Birth

☐☐ / ☐☐ / ☐☐☐☐

Patient (Last Name, First Name, MI)

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PRESCRIBER INFORMATION

Prescriber (Last Name, First Name, MI)

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Prescriber Street Address

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City   **State**   **Zip Code**

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Prescriber Phone: **Prescriber Fax:**

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Indicate area of practice (such as Internal Medicine, Psychiatry, Family Practice). _____

NPI# ☐☐☐☐☐☐☐☐☐☐

Remainder of Form to be Completed by Prescriber

Current Drug Regimen _____

Requested Drug Name and Strength

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Quantity _____   **Requested length of therapy** _____

Directions for use _____

Clinical Justification for Quantity Limit Overide _____

_____

Diagnosis (Do not use ICD codes) _____

Please check all that apply:

○ Yes ○ No   1. **Patient's dose is being titrated and will change within a few weeks. (PA only valid one time up to 60 days)**

○ Yes ○ No   2. **Patient has failed recommended regimen and requires more frequent dosing to receive clinical benefits of drug**

○ Yes ○ No   3. **Other reason, please specify** _____

Date

Signature of Prescriber _____   ☐☐ / ☐☐ / ☐☐☐☐

You will be notified of approval or denial within the next business day.

FAX TO: Maryland Medicaid Pharmacy Program

34141

Fax: (866) 440 - 9345
PA HELPDESK: (800)932-3918