

**Date:** [Date]

**To:** [Insurance Company Name/Pharmacy Benefit Manager]

**Attn:** Appeals/Prior Authorization Department

**Fax Number:** [Fax Number]

**RE:** Request for Quantity Limit Exception

**Patient Name:** [Patient Full Name]

**Date of Birth:** [Patient DOB]

**Member ID:** [Member ID Number]

**Group Number:** [Group Number]

**Case Reference Number:** [Reference Number, if applicable]

Dear Medical Reviewer,

I am writing to formally request a quantity limit exception for my patient, [Patient Name], regarding the medication [Medication Name, Strength, and Dosage Form].

**Diagnosis:** [List specific chronic pain condition, e.g., Chronic Intractable Pain, Failed Back Surgery Syndrome, etc.]

**ICD-10 Code:** [Insert Code]

**Clinical Justification:**

The patient has been under my care for [Duration of Time]. We have attempted to manage their chronic pain within the standard quantity limits; however, the current allowed amount is insufficient to provide adequate pain control and functional stability.

**Previous Therapies Attempted:**

The patient has previously tried and failed the following treatments/medications:

- [Medication/Therapy 1]: [Reason for failure/inadequate response]
- [Medication/Therapy 2]: [Reason for failure/inadequate response]
- [Medication/Therapy 3]: [Reason for failure/inadequate response]

**Requested Quantity:**

I am prescribing [Specific Quantity, e.g., 120 tablets] per [30 days] to ensure the patient maintains a consistent therapeutic level and avoids breakthrough pain that leads to emergency department visits or loss of daily function.

Failure to provide the requested quantity would result in a significant decline in the patient's physical health and quality of life. I have monitored this patient closely for signs of misuse and have a signed pain management contract on file.

Please expedite this request to ensure there is no interruption in the patient's treatment plan. If you require additional clinical documentation, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Clinic/Practice Name]

[Phone Number]

[Fax Number]