US Family Health Plan
Age/Quantity Limit Form

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan pharmacy program. US Family Health Plan is a TRICARE contractor for DoD.

MAIL ORDER	**If the prescription is to be filled through the USFHP Mail Order Pharmacy, check here** ☐ • The completed form may be **faxed** to **1-617-562-5296** OR • The patient may attach the completed form to the prescription and **mail** it to: **Attn: Pharmacy, 77 Warren St, Brighton, MA 02135**	RETAIL	**If the prescription is to be filled at a retail pharmacy, check here** ☐ • The provider may **call 1-877-880-7007** OR • The completed form may be **faxed** to **617-562-5296**

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____
Address: _____
_____
Member ID # _____
Date of Birth _____

Prescriber Name: _____
Address: _____
_____
Specialty: _____
Phone #: _____
Secure Fax #: _____

Step 2 **Provide information supporting the necessity for the following exceptions:**

☐ Age Limit Exception ☐ Quantity Limit Override

Frequency/Quantity/Duration: _____

Diagnosis for which the medication is being prescribed: _____

Other medications tried in the same category: _____

Reason quantity limit needs to be exceeded: _____

Step 3 **I certify the above is true to the best of my knowledge.**

Prescriber Signature: _____ Date: _____