



**Neighborhood Health Plan Of Rhode Island
Benefit Exception Request Form
BRAND NAME Angiotensin Receptor Blockers**

Instructions:

This form is to be used by participating physicians and providers to obtain coverage for a drug with restrictions or for a non-formulary drug for which there is no suitable alternative. *Failure to complete this form will result in NHPRI not paying for the ordered drug and may delay delivery of the drug to your patient.* Please complete this form and **fax to: NHPRI Customer Service at fax # 866-423-0945.**
To review the entire NHPRI Formulary, please visit our website at:
http://www.nhpri.org/internet/nhpri/Providers/pharmacy_services/nhpri_formulary_Menu.htm

Please complete the following information:

Date of Request: ____/____/____

Prescriber Name: (required) _____ Address (required) _____ City _____ Zip _____	Member Name: (required) _____										
Prescriber Specialty: (required) _____	Member ID Number, otherwise SSN#: (required) <table border="1" style="width: 100%; height: 20px;"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>										
Tel # & extension: (required) () -	Member Date of Birth: (required)										
Office Fax Number: (required) () -	Member Sex: M F (Circle One)										
Contact Person at Office:											

Medication requested: _____ **Strength:** _____

Quantity: _____ **Day Supply** _____ **Directions:** _____

Diagnosis _____

Neighborhood provides coverage for ARBs only when the patient has demonstrated intolerance to an ACE-I and has failed to achieve an adequate clinical response to a combination of at least 2 generic antihypertensive agents.

Patient has demonstrated **intolerance** following a trial of an appropriate dose and duration of therapy using any ACE-I.

AND

Patient has failed to achieve adequate response to therapy using a combination of any 2 of the following (check all that apply) ***Not required for Patients with Diabetes, CHF and/or Kidney disease.** ____ **Check here if patient has Diabetes, CHF or Kidney Disease**

- Thiazide Diuretic
- CCB
- Betablocker

Use of generic and/or formulary agents is **contraindicated** in patient. Must provide specific contraindication:

No generic or Formulary agent is FDA approved for the treatment of the patient's disease or condition

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's Signature _____ NPI _____ Date _____

For updated Neighborhood pharmacy information, please supply email address _____

Completed form must be faxed to **Neighborhood Customer Service at fax # 866-423-0945.**