



**Neighborhood Health Plan Of Rhode Island
Benefit Exception Request Form for Patients covered under
the "generic first" benefit
BRAND NAME Angiotensin Receptor Blockers**

Instructions:

The General laws of the State of RI provide for a "generic first" Pharmacy Benefit for the State's Managed Medicaid program. Use of brand name drugs is limited to specific "exempt" drug classes and cases where there is documented evidence that the patient has tried and failed therapy with generic drugs. This form is to be used by participating physicians and providers to obtain coverage for a brand name drug when there is evidence that the patient has tried and failed therapy with generic drugs. *Failure to complete this form will result in Neighborhood not paying for the ordered drug and may delay delivery of the drug to your patient.*

Please complete this form and fax to: Neighborhood Customer Service at fax # 866-423-0945.

To review the entire Neighborhood Formulary, please visit our website at:

http://www.nhpri.org/matriarch/MultiPiecePage.asp_Q_PageID_E_356

Please complete the following information:

Date of Request: ___/___/___

Prescriber Name: (required) _____ Address (required) _____ City _____ Zip _____	Member Name: (required) _____ Member ID Number, otherwise SSN#: (required) <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
Prescriber Specialty: (required) _____ 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 Brand Name ARBs only when the patient has demonstrated intolerance to an ACE-I and losartan *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 losartan.

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.**