Neighborhood Health Plan Of RI

Pharmacy Benefit Exception Request Form

Customer Service (401) 459-6020, fax 866-423-0945

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

Date of Request: ____/_____/_____

Please complete the following information:

Member Name: (required)	**Member ID Number, otherwise SSN#:** (required)
Member Date of Birth: (required) / /	**Member Sex:** M F (Circle One)
Prescriber Name: (required) **Prescriber Specialty:** (required)	**Contact Person at Office:**
Tel # & extension: (required) ( ) -	**Office Fax Number:** (required) ( ) -

Medication requested: ________________________________ Strength: _________________

Quantity: _________ Day Supply ______Directions: ___________________________________

Diagnosis_________________________ Length of Treatment: __________________________

Has patient started treatment with the requested drug? ________If yes, how long? ___________

Please check and complete all that apply:

- ❑ The use of Formulary Drug Products is contraindicated for the patient. Please explain _________
  ____
- ❑ The patient has failed an appropriate trial of Formulary or related agents. Please indicate Formulary agents and mg dosages tried:
  ____ Please indicated date(s) of failure: ____
- ❑ The choices available in the Drug Formulary are not suited for the present patient care need and the drug selected is required for patient safety. Please explain: _____________________________
  ____
- ❑ The use of a Formulary Drug Product may provoke an underlying medical condition, which would be detrimental to patient care. Please explain: _______________________________________
  ____
- ❑ Other rationale for benefit exception request. Please explain: ____________________________
  ____

All information provided on this form is accurate as of this date.

Prescriber's Signature________________________NPI_____________ Date___________

For updated NHPRI pharmacy information, please supply email address ___________________

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