



Neighborhood Health Plan Of RI
Pharmacy Benefit Exception Request Form for RItCare Patients
(Group #1100) covered under the "generic only" benefit
Miscellaneous Brand Name Drugs

Instructions:

Chapter 40-21-1, Article 10 Substitute A as amended of the General laws of the State of RI provide for a "generic only" Pharmacy Benefit for the State's RItCare 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 NHPRI 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) _____										
Prescriber Specialty: (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>										
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 _____ **Length of Treatment:** _____

Please check and complete all that apply

Inadequate Response	<input type="checkbox"/> Patient has failed to achieve an adequate clinical outcome following a trial of an appropriate dose and duration of therapy using generic and Formulary agents. Must indicate all generic and Formulary agents tried: <ul style="list-style-type: none"> <input type="radio"/> Drug/Dose _____ Date failed _____ <input type="radio"/> Drug/Dose _____ Date failed _____ <input type="radio"/> Drug/Dose _____ Date failed _____ <input type="radio"/> Drug/Dose _____ Date failed _____
Intolerance	<input type="checkbox"/> Patient has failed therapy with generic and Formulary agents due to side effects and/or intolerance . Side effect and/or intolerance is documented in patient's medical record. Must indicate all agents tried: <ul style="list-style-type: none"> <input type="radio"/> Drug _____ Side effect _____ <input type="radio"/> Drug _____ Side effect _____ <input type="radio"/> Drug _____ Side effect _____
Contraindicated/ Not available	<input type="checkbox"/> Use of generic and/or Formulary agents is contraindicated in patient. Must provide specific contraindication: <input type="checkbox"/> 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.**