



Neighborhood Health Plan Of Rhode Island
Pharmacy Benefit Exception Request Form for Patients covered under
the "generic first" benefit
BRAND NAME Antihistamines

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.nhpr.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;"> <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 of Allergic Rhinitis

Patient has **failed to achieve an adequate clinical outcome or experienced side effects/intolerance** following a trial of an appropriate dose and duration of therapy with all of the generic agents listed below. **Must indicate all generic and Formulary agents tried:**

Drug	Dose	Inadequate outcome	Date	Side effect	Description of Side Effect
Cetirizine		<input type="checkbox"/>		<input type="checkbox"/>	
Fexofenadine		<input type="checkbox"/>		<input type="checkbox"/>	
Loratadine		<input type="checkbox"/>		<input type="checkbox"/>	
Nasal Steroid		<input type="checkbox"/>		<input type="checkbox"/>	

Diagnosis of Urticaria or Other (describe) _____

Patient has **failed to achieve an adequate clinical outcome or experienced side effects/intolerance** following a trial of an appropriate dose and duration of therapy with both generic agents listed below. **Must indicate all generic and Formulary agents tried:**

Drug	Dose	Inadequate outcome	Date	Side effect	Description of Side Effect
Cetirizine		<input type="checkbox"/>		<input type="checkbox"/>	
Fexofenadine		<input type="checkbox"/>		<input type="checkbox"/>	

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.**