

# Neighborhood Health Plan Of RI

## Pharmacy Benefit Exception Request Form

### Second Generation Antipsychotic (SGA) agents

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. 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>

<b>Member Name:</b> (required) _____	<b>Member ID Number, otherwise SSN#:</b> (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> </tr> </table>								
<b>Member Date of Birth:</b> (required)    /    /	<b>Member Sex:</b> M      F      (Circle One)								
<b>Prescriber Name:</b> (required) <b>Prescriber Specialty:</b> (required)	<b>Contact Person at Office:</b>								
<b>Tel # &amp; extension:</b> (required) (    ) -	<b>Office Fax Number:</b> (required) (    ) -								

**Medication requested:** \_\_\_\_\_ Strength: \_\_\_\_\_  
Quantity: \_\_\_\_\_ Day Supply \_\_\_\_\_ Directions: \_\_\_\_\_  
Diagnosis \_\_\_\_\_  
Has patient started treatment with the requested drug? \_\_\_\_\_ If yes, how long? \_\_\_\_\_

**Risperidone is Neighborhood's preferred SGA agent in patients who are:**

- Treatment naïve and/or
- Switching SGA agents and have not yet attempted a trial with risperidone.

**For requests for all SGA agents other than risperidone please indicate which of the following applies (check all that apply):**

- Patient has failed risperidone therapy due to excessive (greater than 7%) weight gain or has documented significant metabolic changes (glucose, lipids, etc.)  
Dates \_\_\_\_\_
- Patient has failed risperidone therapy due to EPS related side effects.  
Dates \_\_\_\_\_
- Patient is being treated for a condition for which risperidone is not FDA approved.  
Please describe condition \_\_\_\_\_
- Patient has been stable on requested drug for greater than 8 weeks
- Other. Please provide details \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 \_\_\_\_\_

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