

**Neighborhood Health Plan Of Rhode Island  
Pharmacy Benefit Exception Request Form  
Long Acting Injectable (LAI) Antipsychotic agents - (Risperdal Consta, Invega  
Sustenna and Zyprexa Relprevv)**

**Customer Service 1-401-459-6020, 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: Neighborhood Customer Service at fax # 866-423-0945.** To review the entire Neighborhood 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> <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?** \_\_\_\_\_

**Neighborhood provides coverage for LAI antipsychotic agents only when used for the treatment of patients who have had one, or more, psychiatric related inpatient admissions within the 6 month period prior to the initiation of LAI therapy.**

**Please provide the following information:**

**Has the patient had a psychiatric related inpatient admission (circle one)    YES    NO**  
**Please provide the date of last psychiatric related inpatient admission** \_\_\_\_\_  
**Has the patient receive LAI therapy in the past (circle one)    YES    NO**  
**Please provide the date that LAI therapy was initiated** \_\_\_\_\_

**Approval Length:**

Unless otherwise indicated, requests will be approved for 1 year.

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.**