

**Neighborhood Health Plan Of RI
Botox Prior Auth Form
Customer Service (401) 459-6020, fax 866-423-0945**

Rx

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.nhpr.org/>

Date of Request: ___/___/___

Please complete the following information:

Member Name: (required)	Member ID Number, otherwise SSN#: (required) <table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>										
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: BOTOX 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 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 _____

BOTOX can not be picked up at the patient's pharmacy. Provider's office must buy and bill BOTOX to NHPRI.