

**Neighborhood Health Plan Of RI
Pharmacy Benefit Exception Request Form
Chantix® (varenicline)
Customer Service (401)-459-6020, fax 866-423-0945**



Instructions:
If criteria are met, Chantix® will be approved for an initial 12 week course of therapy. Upon documentation of smoking abstinence at 12 weeks, an additional 12 weeks will be authorized. A maximum of two initial 12 week trials will be covered per 12 month period.

Date of Request: ____/____/____

Please complete the following information:

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

NHPRI's goal is to support its smoking members' efforts to quit. Available formulary products include nicotine gum, nicotine transdermal patches, and bupropion SR (Zyban®)

Barring contraindications, a therapeutic trial of bupropion SR (Zyban®) and a nicotine product within the past 12 months is required prior to coverage of Chantix®. The patient **MUST** also be enrolled in a supportive smoking cessation program.

Please check the applicable box(es)

<input type="checkbox"/> Patient is enrolled in a supportive smoking cessation program (REQUIRED) <input type="checkbox"/> Patient has completed a trial of bupropion SR for >6 weeks and has not made significant progress towards abstinence or patient has tried, but did not tolerate, bupropion SR therapy (REQUIRED) <input type="checkbox"/> Patient has completed a trial of Nicotine gum or patch for >6 weeks and has not made significant progress towards abstinence or patient has tried, but did not tolerate, Nicotine therapy (REQUIRED) <input type="checkbox"/> Patient is NOT a candidate for bupropion SR therapy (please explain) _____ <input type="checkbox"/> Other (Please Document)_____

For Renewals <input type="checkbox"/> Patient is completing a 12 week course, and is currently not smoking.

All information provided on this form is accurate as of this date.

Prescriber's Signature _____ NPI _____ Date _____

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