

**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:

<b>Member Name:</b> (required)	<b>Member ID Number, otherwise SSN#:</b> (required) <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></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) ( ) -										

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) Dates (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) Dates (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) Dates (required) _____
<input type="checkbox"/> Patient is NOT a candidate for bupropion SR therapy (please explain) _____
<input type="checkbox"/> Other (Please Document) _____

<b>For Renewals</b> <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.**  
Updated Dec 2009