

**Neighborhood Health Plan Of RI
Pharmacy Benefit Exception Request Form
COZAAR**

Pharmacy Help Desk 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. *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: www.nhpri.org

Please complete the following information:

Member Name: (required)	Member ID Number, otherwise SSN#: (required)
	<input type="text"/>
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: COZAAR

IT IS NHPRI POLICY THAT COZAAR APPROVAL IS LIMITED TO PATIENTS WITH DIABETES, CONGESTIVE HEART FAILURE AND RENAL FAILURE WHO HAVE FAILED TRIAL OF AT LEAST TWO AVAILABLE ACE INHIBITORS OR WHO DO NOT TOLERATE ACE INHIBITOR DUE TO ACE INHIBITOR ASSOCIATED COUGH.

THE PREFERRED ARB IN SUCH CASES IS COZAAR.

INFORMATION REQUIRED FOR PRIOR AUTHORIZATION OF COZAAR

- 1) ELIGIBLE DIAGNOSIS? -----DIABETES
-----CHF
-----RENAL FAILURE
- 2) LIST NAMES OF ACE INHIBITORS TRIALED TO DATE:
1) _____
2) _____
- 3) PATIENT HAS ACE INHIBITOR ASSOCIATED COUGH _____

Prescriber's Signature _____ NPI _____ Date _____

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