



**Neighborhood Health Plan of Rhode Island
Prior Authorization Form
Dovonex® (calcipotriene) Solution, Ointment and
Cream**

Instructions:
 The General laws of the State of RI provide for a “generic first” Pharmacy Benefit for the State’s Managed Medicaid program. Use of brand name drugs is limited to specific “exempt” drug classes and cases where there is documented evidence that the patient has tried and failed therapy with generic drugs. This form is to be used by participating physicians and providers to obtain coverage for a brand name drug when there is evidence that the patient has tried and failed therapy with generic drugs. *Failure to complete this form will result in Neighborhood not paying for the ordered drug and may delay delivery of the drug to your patient.*
 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/matriarch/MultiPiecePage.asp_Q_PageID_E_356

Please complete the following information:

Member Name: (required)	Member ID Number: (required)
Member Date of Birth: (required) / /	Member Sex: M F (Circle One)
Prescriber Name: (required)	Contact Person at Office:
Office Phone number: (required) () -	Office Fax Number: (required) () -

Drug Requested _____ **Directions** _____

Calcipotriene Solution or Ointment
 Neighborhood requires that patients fail at least one medium, high or very high potency topical steroid prior to the use of calcipotriene Solution or Ointment. Please indicate all medium, high or very high potency topical steroids failed:

Drug _____ Date _____ Inadequate response Intolerance _____

Drug _____ Date _____ Inadequate response Intolerance _____

Dovonex Cream
 Neighborhood requires that patients fail at least one medium, high or very high potency topical steroid AND generic calcipotriene solution or ointment prior to the use of Dovonex Cream. Please indicate if patient failed generic calcipotriene and list all medium, high or very high potency topical steroids failed:

Patient failed generic calcipotriene Date _____ Inadequate response Intolerance _____

Drug _____ Date _____ Inadequate response Intolerance _____

Drug _____ Date _____ Inadequate response Intolerance _____

Low Potency Fluocinolone 0.01% Desonide 0.05% Hydrocortisone 1%, 2.5%	Medium Potency Betamethasone Diprionate 0.05% Betamethasone Valerate cr 0.1% Desoximetasone 0.05% Fluocinolone 0.025% Triamcinolone 0.025%,0.1%	High Potency Betamethasone Diprionate cr 0.05% Desoximetasone 0.05%, 0.25% Betamethasone Valerate oint 0.1% Fluocinonide 0.05% Augmented Betamethasone Diprionate cream 0.05%	Very High Potency Augmented Betamethasone Diprionate oint 0.05 Clobetasol 0.05% Diflorasone 0.05%
---	---	---	---

Signature _____ **NPI** _____ **Date** _____

Please fax completed form to NHPRI at 866-423-0945