



**Neighborhood Health Plan Of RI**  
**Pharmacy Benefit Exception Request Form for RlteCare Patients**  
**(Group #1100) covered under the "generic only" benefit**  
**BRAND NAME EIPEN and EIPEN JR**

**Instructions:**

Chapter 40-21-1, Article 10 Substitute A as amended of the General laws of the State of RI provide for a "generic only" Pharmacy Benefit for the State's RlteCare 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 NHPRI Formulary, please visit our website at:  
[http://www.nhpri.org/matriarch/MultiPiecePage.asp\\_Q\\_PageID\\_E\\_356](http://www.nhpri.org/matriarch/MultiPiecePage.asp_Q_PageID_E_356)

Please complete the following information:

Date of Request: \_\_\_/\_\_\_/\_\_\_

<b>Prescriber Name:</b> (required) _____ <b>Address</b> (required) _____ <b>City</b> _____ <b>Zip</b> _____	<b>Member Name:</b> (required) _____										
<b>Prescriber Specialty:</b> (required) _____	<b>Member ID Number, otherwise SSN#:</b> (required) <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
<b>Tel # &amp; extension:</b> (required) (     ) - _____	<b>Member Date of Birth:</b> (required) _____										
<b>Office Fax Number:</b> (required) (     ) - _____	<b>Member Sex:</b> M     F     (Circle One)										
<b>Contact Person at Office:</b> _____											

**Medication requested:** \_\_\_\_\_ **Strength:** \_\_\_\_\_

**Quantity:** \_\_\_\_\_ **Day Supply** \_\_\_\_\_ **Directions:** \_\_\_\_\_

**Diagnosis (specific allergy)** \_\_\_\_\_

Please describe the type of allergic reaction experienced by the patient

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_

For updated Neighborhood pharmacy information, please supply email address \_\_\_\_\_

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