



**Neighborhood Health Plan Of RI  
Pharmacy Benefit Exception Request Form for  
Incivek® (telaprevir)**

Member Name _____	Member Number _____
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DOB: _____	
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Prescriber Name _____	Office Contact _____
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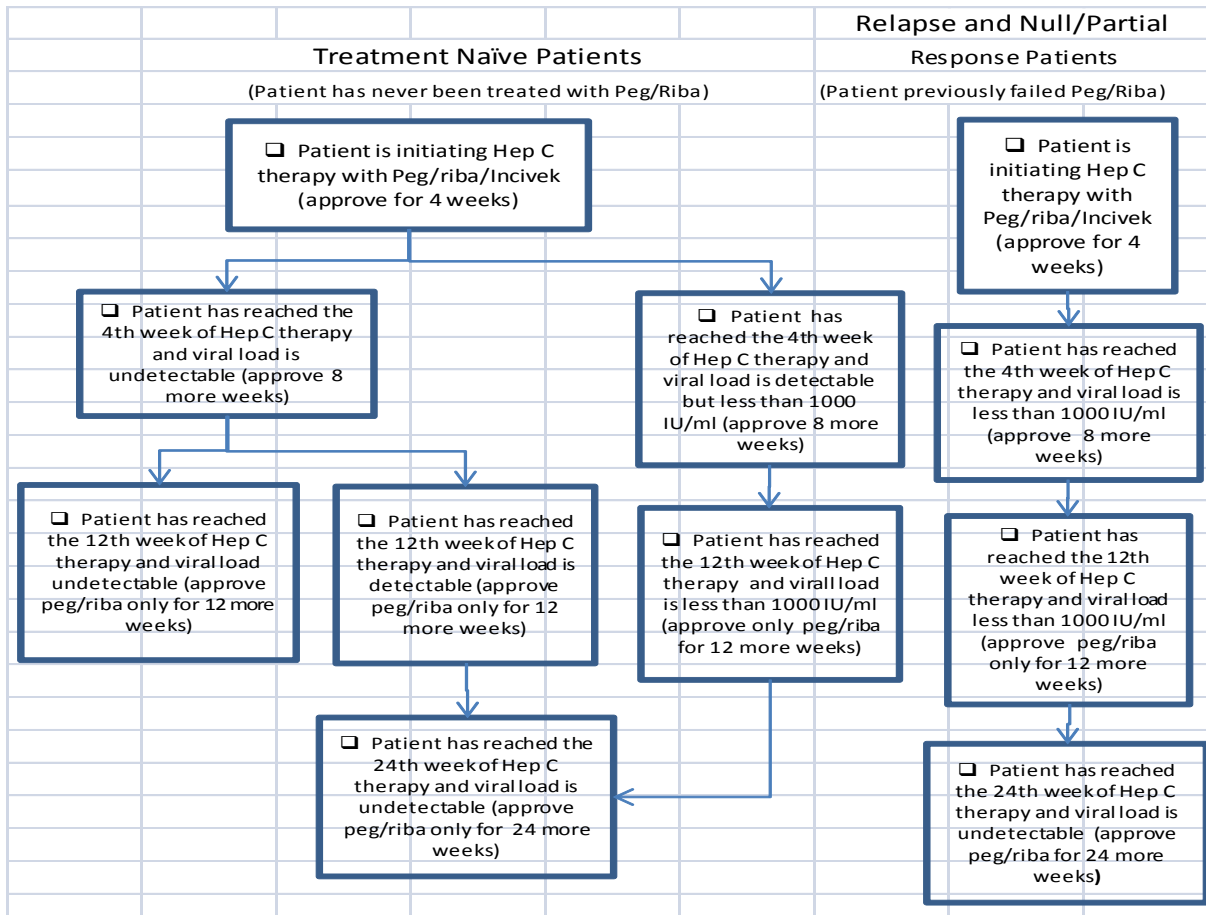
Office Phone _____	Office Fax _____
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Check all that apply:

- Patient is diagnosed with Chronic Hepatitis C Genotype 1 with compensated liver disease
- Patient is also diagnosed with HIV and/or Hepatitis B
- Patient has cirrhosis

**Neighborhood's preferred Hepatitis C protease inhibitor is Victrelis®.**  
 Is patient a candidate for treatment with Victrelis®? circle one Yes No  
 If Yes, please complete and submit Victrelis® PA form. If No, please explain and complete the remainder of this PA form:  
 \_\_\_\_\_

On the chart below please indicate the status of the patient's treatment for Hepatitis C by checking the appropriate box documenting treatment course



Prescriber Signature _____	NPI _____	Date _____
Completed forms should be faxed to Neighborhood Customer Service Department @ 866-423-0945		