



Neighborhood Health Plan of Rhode Island
Prior authorization Form
Insulin Pens/Cartridges
 Customer Service (401)-459-6020, Fax 866-423-0945

If approval criteria are met, Neighborhood Health Plan of Rhode Island will authorize coverage of Insulin pens/cartridges. Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance

Member Name (required) _____	Member ID Number: (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> </tr> </table>								
Member Date of Birth: (required) / /									
Prescriber Name: (required)	Contact Person at Office:								
Office Phone number: (required) () -	Office Fax Number: (required) () -								

Neighborhood provides coverage for insulin pens/cartridges only when the patient's visual or physical capacity is inadequate to allow the safe and/or accurate administration of insulin using a vial and syringe

Drug requested _____ Dose _____

Please CHECK the appropriate boxes and fill out the following information:

Patient is diagnosed with vision impairment severe enough to hinder accurate dosing using vials/syringes.

Patient is diagnosed with a condition which prohibits the coordination necessary to manipulate vials/syringes for accurate dosing.

Please specify: _____

Other _____

PRESCRIBER SIGNATURE _____ NPI _____ DATE _____

By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.

Completed forms should be faxed to:
Customer Service Department
NHPRI
866-423-0945