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) | | | | | | | | |
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 a full time student under the age of 18 and requires pen/cartridges for self administration during school sessions
- ☐ 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