Neighborhood Health Plan of Rhode Island

Pharmacy Benefit Exception Request Form

Long Acting Injectable (LAI) Antipsychotic agents - (Risperdal Consta, Invega Sustenna and Zyprexa Relprevv)

Customer Service (401) 459-6020, fax 866-423-0945

Instructions:
This form is to be used by participating physicians and providers to obtain coverage for a drug with restrictions or for a non-formulary drug for which there is no suitable alternative. 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**

Member Name: (required)	**Member ID Number, otherwise SSN#:** (required)
Member Date of Birth: (required) / /	**Member Sex:** M F (Circle One)
Prescriber Name: (required) **Prescriber Specialty:** (required)	**Contact Person at Office:**
Tel # & extension: (required) ( ) -	**Office Fax Number:** (required) ( ) -

Medication requested : ________________________________ Strength: _______________

Quantity: _________ Day Supply ______Directions: ____

Diagnosis____

Has patient started treatment with the requested drug? ________If yes, how long? __________________

Neighborhood provides coverage for LAI antipsychotic agents only when used for the treatment of patients who have had one, or more, psychiatric related inpatient admissions within the 6 month period prior to the initiation of LAI therapy.

Please provide the following information:

Has the patient had a psychiatric related inpatient admission (circle one) YES NO

Please provide the date of last psychiatric related inpatient admission ______________________

Has the patient receive LAI therapy in the past (circle one) YES NO

Please provide the date that LAI therapy was initiated __________________________

Approval Length:
Unless otherwise indicated, requests will be approved for 1 year.

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_______________________NPI____________ Date_____________

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

Updated March 2010