



**Neighborhood Health Plan Of RI  
Pharmacy Benefit Exception Request Form  
BPH agents (Flomax® and Avodart®)**

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. *Failure to complete this form will result in NHPRI not paying for the ordered drug and may delay delivery of the drug to your patient.* Please complete this form and **fax to: NHPRI Customer Service at fax # 866-423-0945.**

To review the entire NHPRI Formulary, please visit our website at:

[http://www.nhpri.org/internet/nhpri/Providers/pharmacy\\_services/nhpri\\_formulary\\_Menu.htm](http://www.nhpri.org/internet/nhpri/Providers/pharmacy_services/nhpri_formulary_Menu.htm)

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

Please complete the following information:

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

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

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

**Diagnosis** \_\_\_\_\_ **Length of Treatment:** \_\_\_\_\_

Has patient started treatment with the requested drug? \_\_\_\_\_ If yes, how long? \_\_\_\_\_

**Please check and complete all that apply:**

**For Flomax®**

Patient has failed trial with terazosin and/or doxazosin.

Date of trial \_\_\_\_\_ Dose \_\_\_\_\_

Please describe the nature of the failure \_\_\_\_\_

**For Avodart®**

Patient has failed trial with finasteride.

Date of trial \_\_\_\_\_ Dose \_\_\_\_\_

Please describe the nature of the failure \_\_\_\_\_

The choices available in the Drug Formulary are not suited for the present patient care need and the drug selected is required for patient **safety**. Please explain: \_\_\_\_\_

The use of a Formulary Drug Product may provoke an underlying medical condition, which would be detrimental to patient care. Please explain: \_\_\_\_\_

**All information provided on this form is accurate as of this date.**

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

Completed form must be faxed to:  
**NHPRI Customer Service at 866-423-0945.**