



Neighborhood Health Plan Of RI
Pharmacy Benefit Exception Request Form for RlteCare Patients
(Group #1100) covered under the "generic only" benefit
Pantoprazole and BRAND NAME Proton Pump Inhibitors

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

Please complete the following information:

Date of Request: ____/____/____

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

Medication requested: _____ **Strength:** _____

Quantity: _____ **Day Supply** _____ **Directions:** _____

Diagnosis _____

Patient has **failed to achieve an adequate clinical outcome or experienced side effects/intolerance** following a trial of an appropriate dose and duration of therapy with all of the generic and Formulary agents listed below. **Must indicate all generic and Formulary agents tried:**

Drug	Dose	Inadequate outcome	Date	Side effect	Description of Side Effect
Omeprazole <i>(must try twice daily dosing)</i>		<input type="checkbox"/>		<input type="checkbox"/>	
Prevacid OTC Tab		<input type="checkbox"/>		<input type="checkbox"/>	

Use of generic and/or formulary agents is **contraindicated** in patient. Must provide specific contraindication:

No generic or Formulary agent is FDA approved for the treatment of the patient's disease or condition

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 _____

For updated Neighborhood pharmacy information, please supply email address _____

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