



**Neighborhood Health Plan of Rhode Island
Pharmacy Benefit Exception Request Form for Rite Care Patients
(Group #1100) Covered Under the "generic only" Benefit
PROVIGIL®**

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:** _____

Neighborhood provides coverage for Provigil® only when used for the treatment of Narcolepsy, obstructive sleep apnea syndrome (OSAS) or shift work sleep disorder (SWSD) and only when the patient has had a documented trial and failure using multiple generic stimulants

Please provide the information requested below:

Patient is being treated for (circle one)	narcolepsy	OSAS	SWSD		
<p>Has the patient failed to achieve an adequate clinical outcome or experienced intolerance following a trial of an appropriate dose and duration of therapy using at least 2 of the generic agents listed below including at least 1 methylphenidate product and 1 amphetamine product (of which 1 must be a long acting formulation)? (circle one) YES NO</p> <p>If "Yes", please provide all requested information regarding all generic and Formulary agents tried.</p>					
Methylphenidate products:					
Drug	Dose	Inadequate outcome	Date	Side effect	Description of Side Effect
Methylphenidate (Methylin®/Ritalin®)		<input type="checkbox"/>		<input type="checkbox"/>	
Methylphenidate SR (Methylin ER®/Ritalin SR/Metadate ER®)		<input type="checkbox"/>		<input type="checkbox"/>	
Amphetamine products:					
Drug	Dose	Inadequate outcome	Date	Side effect	Description of Side Effect
Amphetamine Salts (Adderall®)		<input type="checkbox"/>		<input type="checkbox"/>	
Adderall XR®		<input type="checkbox"/>		<input type="checkbox"/>	
Dextroamphetamine (Dexedrine®/Destrostat®)		<input type="checkbox"/>		<input type="checkbox"/>	
Dextroamphetamine SR (Dexedrine Spansules®)		<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/> Use of generic and/or formulary agents is contraindicated in patient. Must provide specific contraindication:					

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 1-866-423-0945.**