



**Neighborhood Health Plan Of RI  
Pharmacy Benefit Exception Request Form  
BRAND NAME OXYCONTIN**

**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)

Please complete the following information:

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

<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>Contact Person at Office:</b>
<b>Prescriber Specialty:</b> (required)	
<b>Tel # &amp; extension:</b> (required) ( ) -	<b>Office Fax Number:</b> (required) ( ) -

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

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

**Coverage of OXYCONTIN is only provided for the treatment of Chronic Pain (pain persisting for greater than 90 days) when the patient has failed therapy with appropriately dosed Morphine Sulfate and fentanyl patches. Inadequate response to formulary long acting narcotic agents is not considered a reason for failure. Approval will not be granted unless a serious intolerance or contraindication to formulary long acting narcotic agents is documented. Serious intolerance does not include predictable side effects (nausea, sedation) that generally resolve within reasonable time periods.**

Is the patient being treated for Chronic Pain (circle one) Yes No

Has the patient experienced a documented failure on Morphine Sulfate ER/SR (circle one) Yes No <ul style="list-style-type: none"> <li>Date of trial _____ Maximum daily dose given _____</li> <li>Please describe the serious intolerance experienced _____</li> </ul>
Has the patient experienced a documented failure on fentanyl patches (circle one) Yes No <ul style="list-style-type: none"> <li>Date of trial _____ Maximum daily dose given _____</li> <li>Please describe the serious intolerance experienced _____</li> </ul>
<input type="checkbox"/> OxyContin is being used as part of a narcotic medication rotation regimen after use of Morphine ER/SR and fentanyl patches for periods of at least 6 months each.
<input type="checkbox"/> Use of generic and/or formulary agents is <b>contraindicated</b> 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 \_\_\_\_\_

For updated Neighborhood pharmacy information, please supply email address \_\_\_\_\_

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