



Neighborhood Health Plan Of RI
Pharmacy Benefit Exception Request Form for RlTeCare Patients
(Group #1100) covered under the "generic only" benefit
BRAND NAME OXYCONTIN

Instructions:

Chapter 40-21-1, Article 10 Substitute A as amended of the General laws of the State of RI provide for a "generic only" Pharmacy Benefit for the State's RlTeCare program. Use of brand name drugs is limited to specific "exempt" drug classes and cases where there is documented evidence that the patient has tried and failed therapy with generic drugs. This form is to be used by participating physicians and providers to obtain coverage for a brand name drug when there is evidence that the patient has tried and failed therapy with generic drugs. *Failure to complete this form will result in Neighborhood not paying for the ordered drug and may delay delivery of the drug to your patient.* Please complete this form and fax to: Neighborhood Customer Service at fax # 866-423-0945.

To review the entire NHPRI Formulary, please visit our website at:
http://www.nhpri.org/matriarch/MultiPiecePage.asp_Q_PageID_E_356

Please complete the following information:

Date of Request: ___/___/___

Member Name: (required)	Member ID Number, otherwise SSN#: (required) <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>
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** _____

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"> • Date of trial _____ Maximum daily dose given _____ • Please describe the serious intolerance experienced _____ _____
Has the patient experienced a documented failure on fentanyl patches (circle one) Yes No <ul style="list-style-type: none"> • Date of trial _____ Maximum daily dose given _____ • Please describe the serious intolerance experienced _____ _____
<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 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 _____

For updated Neighborhood pharmacy information, please supply email address _____

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