



Neighborhood Health Plan Of RI
Pharmacy Benefit Exception Request Form for Patients covered
under the "generic first" benefit
BRAND NAME Proton Pump Inhibitors

Instructions:

The General laws of the State of RI provide for a "generic first" Pharmacy Benefit for the State's Managed Medicaid 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 Neighborhood Formulary, please visit our website at:

http://www.nhpr.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)
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 (must try twice daily dosing)		<input type="checkbox"/>		<input type="checkbox"/>	
*pantoprazole		<input type="checkbox"/>		<input type="checkbox"/>	
**Prevacid OTC		<input type="checkbox"/>		<input type="checkbox"/>	

*omeprazole & pantoprazole are covered as first line agents **Prevacid OTC covered after failure of both omeprazole & pantoprazole

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.**