



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

**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 Rlte Care 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 1-866-423-0945. To review the entire Neighborhood Formulary, please visit our website at [http://www.nhpri.org/matriarch/MultiPiecePage.asp\\_Q\\_PageID\\_E\\_356](http://www.nhpri.org/matriarch/MultiPiecePage.asp_Q_PageID_E_356)

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

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

If "Yes", please provide all requested information regarding **all** generic and Formulary agents tried.

**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®/Destostat®)		<input type="checkbox"/>		<input type="checkbox"/>	
Dextroamphetamine SR (Dexedrine Spansules®)		<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.**