



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

**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](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:** \_\_\_\_\_

**Diagnosis of MDD or Anxiety Disorder**

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 using at least 4 of the 5 generic agents listed below. **Must indicate all generic and Formulary agents tried:**

Drug	Dose	Inadequate outcome	Date	Side effect	Description of Side Effect
Citalopram		<input type="checkbox"/>		<input type="checkbox"/>	
Fluoxetine		<input type="checkbox"/>		<input type="checkbox"/>	
Sertraline		<input type="checkbox"/>		<input type="checkbox"/>	
Bupropion(XL)		<input type="checkbox"/>		<input type="checkbox"/>	
Benzodiazapine		<input type="checkbox"/>		<input type="checkbox"/>	

**Diagnosis of OCD or Other (describe)** \_\_\_\_\_

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 using at least 4 of the 5 generic agents listed below. **Must indicate all generic and Formulary agents tried:**

Drug	Dose	Inadequate outcome	Date	Side effect	Description of Side Effect
Citalopram		<input type="checkbox"/>		<input type="checkbox"/>	
Fluoxetine		<input type="checkbox"/>		<input type="checkbox"/>	
Sertraline		<input type="checkbox"/>		<input type="checkbox"/>	
Fluvoxamine		<input type="checkbox"/>		<input type="checkbox"/>	
Clomipramine		<input type="checkbox"/>		<input type="checkbox"/>	

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 \_\_\_\_\_ Date \_\_\_\_\_

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

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