



**Neighborhood Health Plan Of RI  
Pharmacy Benefit Exception Request Form  
SINGULAIR  
Pharmacy Help Desk 401-459-6020, fax 866-423-0945**

**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>

Please complete the following information:

<b>Member Name:</b> (required)	<b>Member ID Number, otherwise SSN#:</b> (required)										
	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
<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: SINGULAIR**

**Requested strength (check one)**

- 4MG CHEWS/ PACKET     
  5MG CHEWS     
  10MG TABLETS

**Directions** \_\_\_\_\_ **Quantity:** \_\_\_\_\_

**DIAGNOSIS (CHECK ONE)**

**ASTHMA** (please indicate which of the following asthma related agents the patient is currently using) (check all that apply):

<input type="radio"/> Albuterol	Dose _____	Date last prescribed _____
<input type="radio"/> Xopenex	Dose _____	Date last prescribed _____
<input type="radio"/> Other SA Beta Agonist	Dose _____	Date last prescribed _____

**ALLERGIC RHINITIS** (Singulair is **NOT** covered for Allergic Rhinitis unless the patient has failed a trial with an appropriate dose and duration of therapy with all available formulary alternatives including generic formulations of Claritin, Benadryl, Chlor-Trimeton, Tavist, Zyrtec and Allegra (note generic forms of Allegra will only be covered after failure of both loratadine and cetirizine. Please list all formulary alternatives that that the patient has failed:

Drug _____	Dose _____	Date of trial _____
Drug _____	Dose _____	Date of trial _____
Drug _____	Dose _____	Date of trial _____
Drug _____	Dose _____	Date of trial _____
Drug _____	Dose _____	Date of trial _____
Drug _____	Dose _____	Date of trial _____
Drug _____	Dose _____	Date of trial _____

**All information provided on this form is accurate as of this date.**

Prescriber's Signature \_\_\_\_\_ NPI \_\_\_\_\_ Date \_\_\_\_\_

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