



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

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)
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:** _____

Please provide the following information:

- **Pretreatment Cholesterol Level(s)** LDL _____ HDL _____ TG _____
- **Current Cholesterol Level(s)** LDL _____ HDL _____ TG _____
- **Goal/Target Cholesterol Level(s)** LDL _____ HDL _____ TG _____

Please check all that apply

- Patient has **failed to achieve an adequate clinical outcome or experienced side effects/intolerance** following a trial for an appropriate duration of therapy using up to an **80mg dose** of Simvastatin.

Drug	Dose	Inadequate response	Date	Side effect or intolerance	Description of side effect or intolerance
Simvastatin		<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 _____ 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.