



Neighborhood Health Plan Of RI Pharmacy Benefit Exception Request Form BRAND NAME STATINS

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/internet/nhpri/Providers/pharmacy_services/nhpri_formulary_Menu.htm

Please complete the following information:

Date of Request: ___/___/___

Member Name: <i>(required)</i>	Member ID Number, otherwise SSN#: <i>(required)</i> <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <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> </tr> </table>								
Member Date of Birth: <i>(required)</i> / /	Member Sex: M F (Circle One)								
Prescriber Name: <i>(required)</i> Prescriber Specialty: <i>(required)</i>	Contact Person at Office:								
Tel # & extension: <i>(required)</i> () -	Office Fax Number: <i>(required)</i> () -								

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.