



**Neighborhood Health Plan Of Rhode Island  
Pharmacy Benefit Exception Request Form for Patients covered  
under the "generic first" benefit  
BRAND NAME STATINS**

**Instructions:**

The General laws of the State of RI provide for a "generic first" Pharmacy Benefit for the State's Managed Medicaid 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 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>Contact Person at Office:</b>
<b>Prescriber Specialty:</b> (required)	<b>Office Fax Number:</b> (required) ( ) -
<b>Tel # &amp; extension:</b> (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 **40 mg 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.**