

**Neighborhood Health Plan Of RI**  
**Pharmacy Benefit Exception Request Form**  
**Suboxone (buprenorphine/naloxone)      Subutex (buprenorphine)**



**Customer Service (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. 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>

<b>Member Name:</b> (required) _____	<b>Member ID Number, otherwise SSN#:</b> (required) <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> <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 requested (please circle one):**    **SUBOXONE/ SUBUTEX** Strength: \_\_\_\_\_  
 Quantity: \_\_\_\_\_ Day Supply \_\_\_\_\_ Directions: \_\_\_\_\_  
 Diagnosis \_\_\_\_\_  
 Has patient started treatment with the requested drug? \_\_\_\_\_ If yes, how long? \_\_\_\_\_

**Neighborhood provides coverage for buprenorphine only when  
 ordered by a duly “waivered/authorized” provider and when used for  
 the treatment of opioid addiction.**

**Please provide the following information:**

Provider Buprenorphine “Waiver” Identification Number: \_\_\_\_\_  
**IF THIS IS NOT PROVIDED THE REQUEST WILL BE DENIED**

Buprenorphine is being prescribed to this member for the purpose of treating opiate addiction and not for the treatment of pain. (Circle one)    Yes      No

If member is female, a pregnancy test has been performed and is negative Yes/No  
 Date of last pregnancy test \_\_\_\_\_

**Approval Length:**

Unless otherwise indicated, requests will be approved for 1 year. \_\_\_\_\_

**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 \_\_\_\_\_

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