



Neighborhood Health Plan Of RI
Pharmacy Benefit Exception Request Form for Patients covered
under the “generic first” benefit
BRAND NAME Triptans

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_PagelD_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) Prescriber Specialty: (required)	Contact Person at Office:
Tel # & extension: (required) () -	Office Fax Number: (required) () -

Medication requested: _____ **Strength:** _____

Quantity: _____ **Day Supply** _____ **Directions:** _____

Patient has **failed to achieve an adequate clinical outcome or experienced side effects/intolerance** following a trial of an appropriate dose and duration of therapy with both of the generic agents listed below. **Must indicate all generic:**

Drug	Dose	Inadequate outcome	Date	Side effect	Description of Side Effect
Sumatriptan		<input type="checkbox"/>		<input type="checkbox"/>	
Naratriptan (must fail sumatriptan 1 st)		<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 NHPRI pharmacy information, please supply email address _____

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