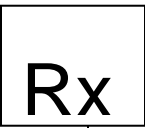


**Neighborhood Health Plan Of RI
Pharmacy Benefit Exception Request Form
Customer Service (401) 459-6020, fax (401)-427-6754**



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 # 401-427-6754.**

To review the entire NHPRI Formulary, please visit our website at:

http://www.nhpri.org/internet/nhpri/Providers/pharmacy_services/nhpri_formulary_Menu.htm

Date of Request: ___/___/___

Please complete the following information:

Member Name: (required)	Member ID Number, otherwise SSN#: (required)										
	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>										
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:** _____

Diagnosis _____ **Length of Treatment:** _____

Has patient started treatment with the requested drug? _____ If yes, how long? _____

Please check and complete all that apply:

- The use of Formulary Drug Products is contraindicated for the patient. Please explain _____

- The patient has failed an appropriate trial of Formulary or related agents. Please indicate
Formulary agents tried: _____
Please indicated date(s) of failure: _____
- The choices available in the Drug Formulary are not suited for the present patient care need and
the drug selected is required for patient safety. Please explain: _____

- The use of a Formulary Drug Product may provoke an underlying medical condition, which would
be detrimental to patient care. Please explain: _____

- Other rationale for benefit exception request. Please explain: _____

All information provided on this form is accurate as of this date.

Prescriber's Signature _____ Date _____

For updated NHPRI pharmacy information, please supply email address _____

Completed form must be faxed to **NHPRI Customer Service at fax # (401)-427-6754.**