Neighborhood Health Plan Of RI
Pharmacy Benefit Exception Request Form for RIteCare Patients (Group #1100) covered under the "generic only" benefit
BRAND NAME Fluoroquinolones

Instructions:
Chapter 40-21-1, Article 10 Substitute A as amended of the General laws of the State of RI provide for a "generic only" Pharmacy Benefit for the State's RIteCare 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 NHPRI Formulary, please visit our website at: http://www.nhpri.org/matriarch/MultiPiecePage.asp_Q_PageID_E_356

Please complete the following information: **Date of Request: ____/_____/_____**

Prescriber Name: (required) ___________________________ **Address** (required) _____________________________ **City**______________________________________ **Zip**__________ **Prescriber Specialty:** (required)	**Member Name:** (required)
	Member ID Number, otherwise SSN#: (required)
Tel # & extension: (required) ( ) -	
Office Fax Number: (required) ( ) -	**Member Date of Birth:** (required)
Contact Person at Office:	**Member Sex:** M F (Circle One)

Medication requested: _________________________________ Strength: _________________

Quantity: _________ Day Supply ______Directions: ___________________________________

Diagnosis of Community Acquired Pneumonia
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 using at least 3 of the 5 generic agents listed below. **Must indicate all generic and Formulary agents tried**:

Drug	Dose	Inadequate outcome	Date	Side effect	Description of Side Effect
Any Macrolide (list)______________				❑	
Any 3rd Gen Cephalosporin (list)________________				❑	
High Dose Amoxicillin				❑	
Amox/clavulanic acid				❑	
Doxycycline				❑	

Diagnosis of infection other than Community Acquired Pneumonia (describe) _______________________
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 using at least 3 of the 7 generic agents listed below. **Must indicate all generic and Formulary agents tried**:

Drug	Dose	Inadequate outcome	Date	Side effect	Description of Side Effect
Any Macrolide (list)______________				❑	
Any 3rd Gen Cephalosporin (list)________________				❑	
High Dose Amoxicillin				❑	
Amox/clavulanic acid				❑	
Doxycycline				❑	
Ciprofloxacin				❑	
SMZ-TMP				❑	

❑ No generic or Formulary agent is FDA approved for the treatment of the patient's disease or condition

❑ Use of generic and/or formulary agents is **contraindicated** in patient. Must provide specific contraindication:

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.**