Neighborhood Health Plan of Rhode Island

Pharmacy Benefit Exception Request Form for Patients covered under the "generic first" benefit

BRAND NAME Inhalation assist Devices

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

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: _____

Diagnosis _____

For Children under age 12

Patient has **failed to achieve an adequate clinical outcome or is unable to exercise proper inhalation technique** following a trial with the generic or Formulary agents listed below. **Must indicate all generic and Formulary agents tried**:

Drug	Inadequate outcome	Date	Unable to exercise proper Technique
Traditional inhaler device/mouth piece (list drug) _____	❑		❑

For Adults and Children 12 and older

Patient has **failed to achieve an adequate clinical outcome or is unable to exercise proper inhalation technique** following a trial with the generic or Formulary agents listed below. **Must indicate all generic and Formulary agents tried**:

Drug	Inadequate outcome	Date	Unable to exercise proper Technique
Traditional inhaler device/mouth piece (list drug) _____	❑		❑
MicroSpacer*	❑		❑

*Microspacer is available without restrictions

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.**