



Neighborhood Health Plan of Rhode Island
PROPOXYPHENE CONTAINING PRODUCTS

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

Medication requested: _____ **Strength:** _____

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

- January 2009 two FDA advisory committees recommended removing propoxyphene containing products from the market because associated risks of the products appear to outweigh potential benefits.
- Propoxyphene-containing products remain on the market; but the FDA is requiring that manufacturers: 1) Strengthen the label's boxed warning to emphasize the risk for overdose; 2) Perform a new study on the cardiac effects of propoxyphene at higher than recommended doses.
- Pooled study results have shown that propoxyphene/APAP is not more effective that APAP alone in relieving pain, and less effective than ibuprofen 400mg in post-op pain.

Diagnosis: _____

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 formulary as indicated below. OR Patient has a documented allergy to formulary agents as documented in their chart. Please describe allergic reaction. **Must indicate all generic and Formulary agents tried along with dose, dates of therapy reason for discontinuing medication and description of side effect or allergic reaction:**

Drug	Dose	Inadequate outcome	Date	Side effect	Description of Side Effect or Allergic Reaction
		<input type="checkbox"/>		<input type="checkbox"/>	
		<input type="checkbox"/>		<input type="checkbox"/>	
		<input type="checkbox"/>		<input type="checkbox"/>	
		<input type="checkbox"/>		<input type="checkbox"/>	
		<input type="checkbox"/>		<input type="checkbox"/>	
		<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

Prescriber's Signature _____ NPI _____ Date _____

For updated Neighborhood pharmacy information, please supply email address _____

Completed form must be faxed to **Neighborhood Customer Service at 1-866-423-0945 .**