



Neighborhood Health Plan of Rhode Island Pharmacy Benefit Exception Request Form Suboxone - Subutex

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. 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: www.NHPRI.org.

Please complete the following

Member Name: (required) _____	Member ID Number: (required) <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
Member Date of Birth: (required) / /	Member Sex: M F (Circle One)										
Prescriber Name: (required) _____	Contact Person at Office: _____										
Office Phone number: (required) () -	Office Fax Number: (required) () -										
Medication & strength requested (please circle): Suboxone 8mg/2mg Suboxone 2mg/0.5mg Subutex 2mg Subutex 8mg Quantity: _____ Day Supply _____ Directions: _____ Diagnosis _____ Has patient started treatment with the requested drug? _____ If yes, how long? _____ Provider Buprenorphine "Waiver" Identification Number: _____ IF THIS IS NOT PROVIDED THE REQUEST WILL BE DENIED											
Neighborhood provides coverage for buprenorphine only when ordered by a duly "waivered" provider and when used for the treatment of <u>opioid addiction</u>. Is Buprenorphine being prescribed to this member for the purpose of treating opiate addiction and not for the treatment of pain? (Circle one) Yes No											
Neighborhood authorizes buprenorphine up to a maximum of 24mg/day. If requesting >24mg/day please indicate rationale. _____ _____											
Neighborhood limits the use of Suboxone 2mg/0.5mg tablets to a maximum of 3 tablets/day and does not authorize 2mg tablets to be used concurrently with 8 mg tablets. If requesting 2mg/0.5mg tablets in quantity >3 tablets/day or concurrent use with 8mg tablets please indicate rationale. _____ _____											

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 _____

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