



Neighborhood Health Plan Of RI
Pharmacy Benefit Exception Request Form for Patients covered
under the “generic first” benefit
BRAND NAME Thiazolidinediones (TZD) and DPP-4
Inhibitors

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_PagelD_E_356

Please complete the following information:

Date of Request: ___/___/___

Member Name: (required)	Member ID Number, otherwise SSN#: (required) <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>
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:** _____

Approval criteria for an incretin-mimetic requires that a patient fail an adequate trial with a 2 gram per day dose of metformin and at least one other generic antihyperglycemic medication.

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 all of the generic and Formulary agents listed below. **Must indicate all generic and Formulary agents tried:**

Drug	Dose	Inadequate outcome	Date	Side effect	Description of Side Effect
Metformin		<input type="checkbox"/>		<input type="checkbox"/>	
Sulfonylurea (list all) _____		<input type="checkbox"/>		<input type="checkbox"/>	
Other Generic (list all) _____		<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

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.**