Neighborhood Health Plan OF RHODE ISLAND™

Formulary Exception Request Form
Fax 1-866-423-0945
Pharmacy Dept. Phone 1-401-427-8200

This form is to be used by participating physicians and providers to obtain coverage. Please complete the form by providing all of the following information. Fax the completed form to Neighborhood at **1-866-423-0945**. For real time Coverage Determination decisions, please go to Cover My Meds: https://www.covermymeds.com/epa/caremark/.

Formulary Exception Prior Authorization Form

Enrollee's Name		Date of Birth
Enrollee's Address		
City	State	Zip Code
Phone	Enrollee's Member ID #	

Important Note: Expedited Decisions
If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. ☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 24 HOURS**

Prescriber's Information		
Name and NPI		
Address		
City	State	Zip Code
Office Phone	Fax	
Prescriber's Signature		Date

Diagnosis and Medical Information			
Medication:	Strength and Route of Administration:		Frequency:
New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:		Quantity:
Height/Weight:	Drug Allergies:	Diagnosis:	

Criteria Questions			
1	Is the requested drug/product being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? [Documentation of diagnosis required]	Yes	No
2	Does the prescribed dose and quantity fall within FDA-approved labeling or within compendia-supported dosing guidelines? Please document the dose the member will be taking: _____	Yes	No
3	Is there rationale for why the requested drug/product is medically necessary? Please explain: _____	Yes	No
4	Is this request for continuation of therapy? If yes, please provide start date of therapy: _____ If yes, is patient tolerating treatment and not experiencing any unacceptable toxicity from the drug? _____ If yes, does the patient have disease stabilization or improvement in disease (as defined by established clinical practice guidelines)? Please provide explanation: _____	Yes	No
5	Has the patient tried and failed the required number of formulary alternatives for the given diagnosis? Requirement: 2 in a class with 2 or more alternatives, or 1 in a class with only 1 alternative. If yes, documentation of trials is required for approval. Provide documentation including name of medication(s) tried and reason for treatment failure(s). _____ _____ _____	Yes	No
6	Is the patient unable to take the required number of formulary alternatives for the diagnosis due to intolerance, an expected adverse reaction, patient-specific reasons, or contraindication? If yes, documentation is required for approval. Provide documentation including name of medication(s) unable to take due to intolerance and/or contraindications, whichever is applicable. _____ _____ _____ *If the requested drug is a combination product, then the separate individual components of the combination product taken concurrently must be unable to be taken PLUS the remaining required number of alternatives.* *f the requested drug is a brand product and has a formulary generic for the same active ingredient, then the formulary generic must be unable to be taken PLUS the remaining required number of alternatives.*	Yes	No

	If the requested drug has an available alternative formulary dosage form of the same active ingredient, then an alternative formulary dosage form of the requested drug must be unable to be taken PLUS the remaining required number of formulary alternatives. Please note, requirement for alternative dosage forms apply only if clinically appropriate (e.g., same indication, age appropriateness.)		

After filling out the questionnaire, if there is any additional clinical information that you would like to provide, please indicate below.

_____

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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 _____