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 #	
Do you need this request decisioned 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

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2	Is this a request for continuation of therapy? If yes, please provide start date of therapy: _____	Yes	No
3	Has the patient tried and failed at least the required number of formulary alternatives for the given diagnosis? *Requirement: 3 in a class with 3 or more alternatives, 2 in a class with 2 alternatives, or 1 in a class with only 1 alternative.**Note: Certain drugs may require trial and failure of ALL alternatives.* 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
4	Is the patient unable to take the required number of formulary alternatives for the given 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 contraindication whichever are 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.* *If 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.* *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.)*	Yes	No

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

_____

_____

_____

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 _____