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/.

Step Therapy Criteria 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		
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:

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CRITERIA FOR APPROVAL			
1	Has the patient tried and failed the first line formulary alternatives for the given diagnosis due to a trial and inadequate treatment response, intolerance, contraindication, or an expected adverse reaction? *If yes, documentation is required for approval. Provide documentation including name of medication(s) tried and reason for treatment failure(s), intolerance and/or contraindication whichever are applicable.* _____	Yes	No
2	Is this a request for continuation of therapy? If yes, please provide start date of therapy: _____	Yes	No

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 _____