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/.

Exception 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? (72 hours is our normal turn-around-time)		

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:

CRITERIA FOR APPROVAL

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

1	Is the requested product being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Yes	No
2	Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature?	Yes	No
3	Is the request for a formulary product for more than the initial quantity limit? [If yes, then no further questions.]	Yes	No
4	Is the request for a combination product for which individual components are available at similar doses on formulary? [If no, then skip to question 6.]	Yes	No
5	Has the patient had a trial and failure of the separate individual components due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient? [If no, then no further questions.]	Yes	No
6	Is the request for a brand name product that has a generic available on formulary? [If no, then skip to question 8.]	Yes	No
7	Has the patient had a trial and failure of the generic agent due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient? [If no, then no further questions.]	Yes	No
8	Is the request for a drug with an available alternative dosage form for the same active ingredient on formulary? [If no, then skip to question 10.]	Yes	No
9	Is there a clinical reason why the patient is unable to take an applicable alternative formulary dosage form based on the patient's condition (e.g. age, indication)? [If no, then no further questions.]	Yes	No
10	Is the patient unable to take the required number of formulary alternatives for the given diagnosis due to a trial and inadequate treatment response or intolerance or an expected adverse reaction or contraindication? *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.* _____ *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.)* [If yes, then no further questions.]	Yes	No

11	Does the patient have a clinical condition or need a specific dosage form for which there is no formulary alternative or the listed formulary alternatives are not recommended based on published guidelines or clinical literature OR the formulary alternatives will likely be ineffective or less effective for the patient OR the formulary alternatives will likely cause an adverse effect? [Note: This includes if the patient has visual impairment and the request is for insulin cartridges or diabetic supplies (kit, monitor, test strips) that provides audible test results.] *If yes, documentation is required for approval. Provide documentation including clinical condition, reason for specific dosage form (if applicable), and reason that formulary alternatives cannot be used.* _____	Yes	No