



**Neighborhood Health Plan Of RI  
Pharmacy Benefit Exception Request Form  
BRAND NAME Triptans**

**Instructions:**

This form is to be used by participating physicians and providers to obtain coverage for a drug with restrictions or for a non-formulary drug for which there is no suitable alternative. Please complete this form and **fax to: NHPRI Customer Service at fax # 866-423-0945.** To review the entire NHPRI Formulary, please visit our website at: <http://www.nhpri.org>

Please complete the following information:

Date of Request: \_\_\_/\_\_\_/\_\_\_

<b>Member Name:</b> (required)	<b>Member ID Number, otherwise SSN#:</b> (required)
<b>Member Date of Birth:</b> (required) / /	<b>Member Sex:</b> M    F    (Circle One)
<b>Prescriber Name:</b> (required) <b>Prescriber Specialty:</b> (required)	<b>Contact Person at Office:</b>
<b>Tel # &amp; extension:</b> (required) (    ) -	<b>Office Fax Number:</b> (required) (    ) -

**Medication requested:** \_\_\_\_\_ Strength: \_\_\_\_\_  
Quantity: \_\_\_\_\_ Day Supply \_\_\_\_\_ Directions: \_\_\_\_\_

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 at all\* of the generic agents listed below. **Must indicate all generic:**

Drug	Dose	Inadequate outcome	Date	Side effect	Description of Side Effect
Sumatriptan		<input type="checkbox"/>		<input type="checkbox"/>	
NSAID		<input type="checkbox"/>		<input type="checkbox"/>	
Caffeine product		<input type="checkbox"/>		<input type="checkbox"/>	

\* Patients with documented GI disorder (e.g. Gastric or Peptic ulcer, GERD) are required to fail only 2 of the 3 generic agents listed. Please indicate if patient has documented GI disorder (circle)    Yes    No

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 NHPRI pharmacy information, please supply email address \_\_\_\_\_

Completed form must be faxed to **NHPRI Customer Service at fax # 866-423-0945**