REQUEST FOR PRESCRIPTION DRUG APPEALS FOR PRESCRIBERS

This form must be filled out electronically and emailed to: NHIClinical@vinhi.vg

Enrollee's Information

Enrollee's Name	Date of Birth
Enrollee's Address	
City	The Virgin Islands
Phone	Enrollee's Member ID #

Name of prescription drug you are requesting (if known, include strength and quantity requested per month):

Type of Appeal Request

☐ My patient needs a drug that is not on the NHI's list of covered drugs (formulary).

☐ My patient needs an exception to the prior authorization requirements (please fill out additional information below). This drug was denied under prior authorization.

Supporting Information for Appeal	
Prescriber's Information	
Name	Registration Number
Address	
City	The Virgin Islands
Office Phone	Fax

Prescriber's Signature	Date

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

Rationale for Request

Required Explanation _____

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Signature:	**Date:**

Save **Print** **Submit**