



Department of Vermont Health Access
 312 Hurricane Lane, Suite 201
 Williston, Vermont 05495

BRAND.2
 FORM#03
 R: 1.15

Agency of Human Services

~Brand Name~

Prior Authorization Request Form

In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must complete and fax this form to Goold Health Systems. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-844-679-5366 or Phone: 1-844-679-5363

Prescribing physician:

Beneficiary:

Name: _____
 Physician NPI: _____
 Phone#: _____
 Fax#: _____
 Address: _____
 Contact Person at Office: _____

Name: _____
 Medicaid ID#: _____
 Date of Birth: _____ Sex: _____
 Pharmacy Name _____
 Pharmacy NPI: _____
 Pharmacy Phone: _____ Pharmacy Fax: _____

Drug Requested: _____ **Strength, Route & Frequency:** _____

Expected Length of therapy: _____

1. Has patient tried a generic? Yes Adverse reaction Inadequate response Other _____
2. Details of adverse reaction, inadequate response, or other: (please provide chart notes)

3. Is the side effect experienced also listed in the Brand Drug Side Effect Profile? If no, please explain.

4. What other therapeutic alternatives other than the name brand version were tried first?

5. Patient's diagnosis for use of this medication: _____
6. Previous history of medical condition, allergies or other pertinent medical information, that necessitates the use of this medication: _____
 Was patient seen by any other provider for this condition? YES /NO What specialty? _____
7. Other Information/ Comments:

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

Prescriber Signature: _____ **Date of request:** _____

