



"GENERAL" SPECIALTY - Prior Authorization/Prescription/Patient Enrollment Form

USE WHEN NO DRUG SPECIFIC FORM EXISTS - Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION

Last Name		First Name		Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #		
Allergies: <input type="checkbox"/> NKA or _____				
Street Address		City		
State	County	Zip Code		
Home Phone		Cell Phone		
Parent/Guardian		Day Telephone	Night Telephone	
Emergency Contact		Relationship	Telephone	

2 PRESCRIBER INFORMATION

Prescriber's Name		NPI Number	DEA Number	
Telephone Number	Fax Number	Hospital/Clinic Name		
Street Address		City		
State	County	Zip Code		
Contact Person at Office		Prescriber Specialty		

Fax Completed Form to:

Fax Number: 800-218-3221

Phone Number: 866-843-3604



Goold Health Systems

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**Department of Vermont Health Access
"GENERAL" SPECIALTY MEDICATIONS (Not drug specific)
PRIOR AUTHORIZATION REQUEST**

Patient Diagnosis: _____

Drug Requested: _____

Strength, Route & Frequency: _____

Length of therapy: _____

Previous history of a medical condition, allergies or other pertinent medical information, that necessitates the use of this particular medication: _____

Was patient seen by any other provider for this condition? Yes No

Specialist name: _____ Specialist Type: _____

Medications previously tried and failed for this condition:

Name of medication	Type of failure	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list pertinent laboratory test(s) or procedure(s) if applicable:

Procedure/Test	Findings	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Information/ comments: _____

4 PRESCRIPTION

Drug Name/Strength: _____

Sig: Dose: _____ Route: _____ Frequency: _____

Qty: _____ Refill X: _____

Deliver product to: Patient's home MD office Clinic

Prescriber's Signature: _____ Date: _____