



Department of Vermont Health Access
 NOB 1 South, 280 State Drive
 Waterbury, Vermont 05671-1010

~Asthma: Immunologic Therapies~
Prior Authorization Request Form

In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must fax this form to Change Healthcare. Please complete this form in its entirety, and sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare Helpdesk at 1-844-679-5363.

Submit request via Fax: 1-844-679-5366

Prescribing physician:
 Name: _____
 NPI: _____
 Specialty: _____
 Phone#: _____
 Fax#: _____
 Address: _____
 Contact Person at Office: _____

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

- Patient diagnosis: moderate to severe persistent asthma severe persistent asthma
- Medication from each of the following classes must have been tried and failed prior to consideration:

Therapy:	Specific Drug:	Reason for discontinuation:	Date:
Inhaled Corticosteroid:	_____	_____	_____
Leukotriene Receptor Antagonist:	_____	_____	_____
Long-Acting Beta Agonist:	_____	_____	_____

Xolair Dose: _____ Frequency: _____

- Prescriber is an allergist, immunologist, or pulmonologist: **NO** **YES**
- Positive test to perennial aeroallergen by a skin or blood test: **NO** **YES** , Aeroallergen: _____
- IgE level ≥ 30 and ≤ 700 IU/ml prior to beginning therapy with Xolair: **NO** **YES**
- IgE Level: _____ Date obtained: _____

Nucala Dose: _____ Frequency: _____

- Prescriber is an allergist, immunologist, or pulmonologist: **NO** **YES**
- Pre-treatment FEV1 < 80% predicted: **NO** **YES**
- 2 or more exacerbations in the previous year despite use of maintenance therapies listed above: **NO** **YES**
- Eosinophilic phenotype as defined by pre-treatment blood eosinophil count: **NO** **YES**
- Eosinophil Count: _____ Date obtained: _____

Renewal Requests (Clinical notes documenting member's response to therapy must be submitted):

- Does the patient have documented improvement in FEV1 from baseline? **NO** **YES**
- Does the patient have a decreased frequency of exacerbations or hospitalizations? **NO** **YES**
- Is there documented evidence of a decreased dose/frequency of steroid requirements? **NO** **YES**
- Is there documented evidence of a decreased dose/frequency of rescue medications? **NO** **YES**

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.

Prescribers Signature: _____

Date: _____