



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

Agency of Human Services

~ GENERAL ~

Prior Authorization Request Form

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

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name: _____

Phone #: _____

Fax #: _____

Address: _____

Contact Person at Office: _____

Beneficiary:

Name: _____

Medicaid ID #: _____

Date of Birth: _____ **Sex:** _____

Will this medication be billed through the: **pharmacy benefit** or **medical benefit** (J-code or other code)? **(Please check one)**

Administering Provider if other than Prescriber: (name): _____ NPI #: _____

Pharmacy (if known): _____ Phone: _____ &/or FAX: _____

1. Drug Requested: _____ **Strength, Route & Frequency:** _____ **Length of therapy:** _____
 Brand Name **Generic Equivalent**

2. Patient's diagnosis for use of this medication: _____

3. Previous history of a 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? _____

4. Please list preferred medications previously tried and failed for this condition:

Name of medication	Reason for failure	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Procedure	Findings	Date
_____	_____	_____
_____	_____	_____

6. Other Information/ comments:

Prescriber Signature: _____

Date of this request: _____