



**Department of Vermont Health Access
General Specialty
PRIOR AUTHORIZATION REQUEST**

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

PRESCRIBER'S 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	

**Please Fax Completed for to:
Fax Number 1-800-218-3221
Phone Number 1-866-843-3604**



Patient Diagnosis: _____												
Drug Requested: _____												
Strength, Route & Frequency: _____												
Length of therapy: _____												
Previous history of 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? <input type="checkbox"/> Yes <input type="checkbox"/> No												
Specialist name : _____ Specialist Type: _____												
Medications previously tried and failed for this condition:												
<table border="1"> <thead> <tr> <th>Name of medication</th> <th>Type of failure</th> <th>Date</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Name of medication	Type of failure	Date	_____	_____	_____	_____	_____	_____	_____	_____	_____
Name of medication	Type of failure	Date										
_____	_____	_____										
_____	_____	_____										
_____	_____	_____										
Please list pertinent laboratory test(S) or procedure(s) if applicable:												
<table border="1"> <thead> <tr> <th>Procedure/Test</th> <th>Finding</th> <th>Date</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Procedure/Test	Finding	Date	_____	_____	_____	_____	_____	_____			
Procedure/Test	Finding	Date										
_____	_____	_____										
_____	_____	_____										
Other Information/comments: _____												
PRESCRIPTION												
Drug Name/Strength: _____												
Sig. Dose: _____ Route: _____ Frequency: _____												
Qty: _____ Refill X: _____												
Deliver product to: <input type="checkbox"/> Patient's home <input type="checkbox"/> MD office <input type="checkbox"/> Clinic												
Prescriber's Signature: _____ Date: _____												