



**“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**

**3 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: \_\_\_\_\_