



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

~Long Acting Narcotics~ Prior Authorization Request Form

In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must complete and 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 help desk at 1-844-679-5363.

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

Prescribing physician:

Name: _____
 Physician 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: _____

1. Drug/Dose/Frequency and Length of Therapy:

2. Brand Name or Generic Equivalent

3. Diagnosis or Indication for Use:

4. Has the member previously tried any of the following preferred medications?

Check all that apply:	Response, check all that apply
<input type="checkbox"/> Fentanyl Patches	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> Morphine Sulfate CR 12 Hr Tablet	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> Embeda [®] (Morphine Sulfate/Naltrexone HCl)	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy

For tramadol products, has the member previously tried the following preferred medication?

Check if applicable:	Response, check all that apply:
<input type="checkbox"/> Tramadol immediate release	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy

Is this an initial request or a renewal request?

Initial Renewal

Other Information/ Comments: _____

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.

Prescriber Signature: _____ **Date of request:** _____

