VERMONT

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

Agency of Human Services

~ Exception to VPharm Pilot for Statins and PPIs ~

Effective August 3, 2009, DVHA will only cover the cost-sharing (deductible, donut hole and coinsurance) for select statins (HMG COA reductase inhibitors) and proton pump inhibitors (PPIs) for VPharm Part D-eligible beneficiaries. The covered statins include: all dosage strengths of simvastatin, lovastatin and pravastatin. The covered PPI is omeprazole RX 10 mg, 20 mg or 40 mg.
To request an exception, the prescriber must telephone or complete and fax this form to Goold Health Systems. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-844-679-5366 or Phone: 1-844-679-5363

- Requests for exceptions must be made by a physician or clinical professional licensed to prescribe drugs in Vermont.

Prescribing Physician:

Name:_____
Phone #:_____
Fax #:_____
Address:_____
Contact Person at Office:_____

Beneficiary:

Name:_____
Medicaid ID #:_____
Date of Birth:_____

1. **Drug Requested:**_____ **Strength, Route & Frequency:** _____

   ☐ **Generic Equivalent** ☐ **Brand Name**

2. **Does the patient have a Medicare Part D Plan (PDP) issued prior authorization for the requested medication?**

   ☐ **YES** ☐ **NO** **Please provide name of PDP:** _____

3. **Has the patient tried one covered medication for this indication?** ☐ **YES** ☐ **NO**
4. **Please list medications previously tried and failed for this condition:**

Name of medication	Reason for failure	Date

5. **I am requesting an exception from the VPharm Statin and PPI Pilot program for this medication because:**

   ☐ **The preferred product was ineffective. Please explain:** _____

   ☐ **The preferred product caused adverse or harmful side effects. Please explain:** _____

   ☐ **The prescriber expects that the preferred product may be ineffective or may result in adverse or harmful side effects to the patient. Please explain:** _____

   ☐ **Other: Please explain:** _____

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