



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

REMICADE.2  
 FORM#23  
 R:03.16

Agency of Human Services

~REMICADE~

**Prior Authorization Request Form**

Vermont Medicaid has established coverage limits and criteria for prior authorization of Remicade. In order for beneficiaries to receive Medicaid coverage for Remicade, it will be necessary for the prescriber to complete and fax this prior authorization request to Goold Health Systems. 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 GHS Helpdesk at 1-844-679-5363.

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

Prescribing physician:

Beneficiary:

Name: \_\_\_\_\_  
 Phone#: \_\_\_\_\_  
 Fax#: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Contact Person at Office: \_\_\_\_\_

Name: \_\_\_\_\_  
 Medicaid ID#: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Pharmacy Name \_\_\_\_\_  
 Pharmacy Phone: \_\_\_\_\_ Pharmacy Fax: \_\_\_\_\_

The following **MUST** be completed for **MEDICAL BENEFIT** requests:

- HCPCS J-code or other code: \_\_\_\_\_
- Administering Provider/Facility: Name \_\_\_\_\_ NPI# \_\_\_\_\_ Medicaid ID# \_\_\_\_\_

Please **check box** if this drug is being provided under the DVHA's 340B Drug program and requires the **UD modifier**

Dosage

<u>Drug Brand Name</u>	<u>Strength</u>	<u>Instructions</u>	<u>Quantity</u>	<u>Days Supply</u>	<u>Refills</u>
REMICADE	_____	_____	_____	_____	1 2 3 4

Indication:  Crohn's Disease  Ulcerative Colitis  Rheumatoid Arthritis  Ankylosing Spondylitis  
 Psoriasis (Plaque)  Psoriatic Arthritis

List previous medications tried and failed for this condition:

Name of medication	Reason for failure	Date (s) attempted
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please explain why self-injectables (if indicated but not trialed) cannot be trialed?

\_\_\_\_\_

Prescriber 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:** \_\_\_\_\_

