

~ ULCERATIVE COLITIS INJECTABLE MEDICATIONS ~

Prior Authorization Request Form

Vermont Medicaid has established coverage limits and criteria for prior authorization of Ulcerative Colitis Injectable medications. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for these drugs, it will be necessary for the prescriber to telephone or complete and fax this prior authorization request to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Use this form for Ulcerative Colitis Injectable medication prior authorization requests only.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name: _____

Phone #: _____

Fax #: _____

Contact Person at Office: _____

Beneficiary:

Name: _____

Medicaid ID #: _____

Date of Birth: _____ Sex: _____

Diagnosis: _____

Will this medication be billed through the: pharmacy benefit or medical benefit (J-code or other code) ?

Pharmacy (if known): _____ Phone: _____ &/or FAX: _____

Remicade _____ Strength & Frequency: _____ Length of therapy: _____

For any other injectable Ulcerative Colitis treatment, please explain medical necessity for the specific product:

Drug: _____ Strength & Frequency: _____ Length of therapy: _____

Medical justification:

List previous medications tried and failed for this condition:

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

Prescriber comments:

Prescriber Signature: _____

Date of this request: _____