

~ UNCLASSIFIED DRUGS ~

**Prior Authorization Request Form – Medical Benefit Only**

In order for beneficiaries to receive Medicaid coverage for unclassified medications through the **medical benefit only**, the prescriber must complete and fax this form to the Department of Vermont Health Access. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

**Prescribing physician:**

Name: \_\_\_\_\_  
NPI or VT Medicaid ID# \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Fax #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Contact Person at Office: \_\_\_\_\_

**Beneficiary:**

Name: \_\_\_\_\_  
Medicaid ID #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

1. Drug Requested: \_\_\_\_\_ Unclassified J code: \_\_\_\_\_  
Strength, Route & Frequency: \_\_\_\_\_ Length of therapy: \_\_\_\_\_
2. Administering Provider if other than Prescriber: (name): \_\_\_\_\_ NPI #: \_\_\_\_\_
3. Patient's diagnosis for use of this medication: \_\_\_\_\_
4. Previous history of a medical condition, allergies or other pertinent medical information, that necessitates the use of this medication: \_\_\_\_\_  
Was patient seen by any other provider for this condition? YES / NO What specialty? \_\_\_\_\_

5. Please list preferred medications previously tried and failed for this condition:

Name of medication	Reason for failure	Date
_____	_____	_____
_____	_____	_____

6. Other Information (i.e. pertinent laboratory test(s) or procedure(s) if applicable) / comments:

Prescriber Signature: \_\_\_\_\_ Date of this request: \_\_\_\_\_

