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

CHANGE HEALTHCARE

~ CAR-T Therapy ~

Prior Authorization Request Form

In order for members 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 helpdesk at 1-844-679-5363.

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

Prescribing provider:
Name:_____
Physician NPI: _____
Specialty:_____
Phone#:_____
Fax#:_____
Address:_____
Contact Person at Office: _____

Member:
Name:_____
Medicaid ID#: _____
Date of Birth:_____Sex:_____
Patient's Phone: _____
Pharmacy Name_____
Pharmacy NPI: _____
Pharmacy Phone:_____Pharmacy Fax: _____

The following MUST be completed for MEDICAL BENEFIT requests:

HCPCS J-code(s)_____, CPT code(s): _____

Administering Provider/Facility: Name_____NPI#_____ Medicaid ID#_____

Contact person at facility: _____ Phone # _____ Fax number: _____

Will this require an inpatient stay? Yes ☐ No ☐

- If yes: Date of admission (if known) _____ Date of procedure (if known) _____
- Expected length of inpatient stay: _____

Drug Requested: _____

Patient Weight (kg):_____Dose:_____ (Approval will be for a single dose)

1. Diagnosis for use of this medication:

☐ Follicular Lymphoma, relapsed or refractory
☐ Large B-Cell Lymphoma, relapsed or refractory
☐ Mantle Cell Lymphoma, relapsed or refractory
☐ Multiple myeloma, relapsed or refractory
☐ Precursor B-Cell Acute Lymphoblastic Leukemia
☐ Other:_____

2. Please provide details of prior systemic therapy (clinical notes or other records should be included with request):

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

3. Please list pertinent laboratory test(s) or procedure(s) if applicable:

Procedure	Finding	Date
_____	_____	_____

4. Other Information/ Comments: _____

_____

Transportation information can be found at: https://dvha.vermont.gov/providers/non-emergency-medical-transportation

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 the patient's medical records. I also understand that any misrepresentationsor concealment of any information requested in the prior authorization request may subject me to audit and/or recoupment.

Prescribers Signature: _____ Date: _____