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

~Hemophilia ~

Prior Authorization Request Form

In order for beneficiaries 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 physician:
Name: _____
Physician NPI: _____
Specialty: _____
Phone#: _____
Fax#: _____
Address: _____
Contact Person at Office: _____

Beneficiary:
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 or other code: _____
- Administering Provider/Facility: Name_____ NPI#_____ Medicaid ID#_____

Patient Diagnosis:

☐ Hemophilia A- Factor VIII Deficiency ☐ Factor VII Deficiency

☐ Hemophilia B- Factor IX Deficiency ☐ Von Willebrand Disease

Clinical reason for the request of a non-preferred product (if applicable): _____

_____

Product Name: _____

Patients Weight (kg): _____ Native Factor level: _____

Dose/Frequency Instructions: _____

#of doses order: _____ Refills: _____

If dose of different units are ordered, specific number of doses of each

Reason(s) for Use:

☐ Acute Bleeding Episode ☐ Surgical Prophylaxis ☐ Dental Procedure

☐ Episodic only ☐ Prophylaxis and PRN ☐ Prophylaxis only

Recent bleed while on Prophylaxis:

Date of Bleed: _____/_____/_____ Location of bleed _____ Severity of bleed: _____

# of Dose s already administered prior to this order: _____ IU/Dose: _____

Deliver products to: ☐ Patient's home ☐ MD office ☐ Clinic ☐ Needles/syringes: quantity sufficient for factor supply

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 misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and/or recoupment.

Prescriber's Signature: _____ **Date:** _____

CHANGE HEALTHCARE