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

~Exception to Required 90 Day Maintenance Medication Fill~

To request an exception, 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:

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

- Requests for exceptions must be made by a physician of a clinical professional licensed to prescribe drugs in Vermont.
- Please complete this form only if the Department of Vermont Health Access is the primary payer for the drug.
- Do not complete this form for a new prescription for the beneficiary. The Department of Vermont Health Access allows prescribers a shorter initial refill period to test for therapeutic effectiveness and patients tolerance.

Prescribing physician:
Name: ________________________________
Physician NPI: ________________________
Specialty: ____________________________
Phone#: ______________________________
Fax#: ________________________________
Address: _____________________________
Contact Person at Office: _______________

Beneficiary:
Name: ____
Medicaid ID#: ______________________________________
Date of Birth: ________________________ Sex: ___________
Pharmacy Name_____________________________________
Pharmacy NPI: ______________________________________
Pharmacy Phone: _____________Pharmacy Fax: ___________

1. Drug Requested: _________________________ Strength, Route & Frequency: _______________________
   □ Brand Name □ Generic Equivalent Length of Therapy: _________________________________

2. Patients diagnosis for use of this medication: ____

3. I am requesting an exception from the required 90-day maintenance fill for this medication because:

   □ This medication will not be used as maintenance therapy for this patient
   □ This patient is not yet stabilized on this medication (requires an additional 30-day fill)
   □ This patient is homeless and can not store a 90-day supply of medication
   □ There are extenuating circumstances that justify an exception to the 90-day fill rule:
   PLEASE EXPLAIN:
   ____
   ____
   ____

   Prescriber Signature: ____ Date of this request: ____________________

   If exceptions are being requested for more than one drug, please also use page 2.

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PAGE 2

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

Patient Name: ______________________________________

Patient DOB: ____________________

	DRUG #2	DRUG #3	DRUG #4	DRUG #5	DRUG #6
Drug name/ Strength/ Dosage form					
Route of Administration					
Frequency of Administration					
Brand/ Generic					
Anticipated Length of Therapy					

I am requesting an exception from the required 90-day maintenance fill for this medication because:

	DRUG #2	DRUG #3	DRUG #4	DRUG #5	DRUG #6
This medication will not be used as maintenance therapy for this patient.					
This patient is not yet stabilized on this medication. (requires an additional 30-day fill)					
This patient is homeless and cannot store a 90-day supply of medication.					
There are extenuating circumstances that justify an exception to the 90-day fill rule:					

PLEASE EXPLAIN:

____

____

____

Prescriber Signature: __________________________________ Date of this request: ___________________________