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

~Brand Name~

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 help desk at 844-679-5363.

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

Prescribing physician:

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

Beneficiary:

Name: _____
Medicaid ID#:_____
Date of Birth: _____ **Sex:** _____
Pharmacy Name_____
Pharmacy NPI: _____
Pharmacy Phone: _____**Pharmacy Fax:** _____

Drug Requested:_____ **Strength, Route & Frequency:** _____

Expected Length of therapy:_____

1. Has the patient tried a generic? ☐ Yes ☐ No
2. Outcome of generic trial(s) (recommendation is to try at least 2 different manufacturers):

   ☐Adverse reaction ☐ inadequate response ☐ Other_____
3. Details of adverse reaction, inadequate response, or other: (please provide chart notes)
   _____
   _____
4. What other therapeutic alternatives other than the name brand version were tried first?
   _____
   _____
5. Patient's diagnosis for use of this medication:_____
6. Previous history of 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?_____
7. Other Information/ Comments:
   _____

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 Signature:_____ **Date of request:**_____

CHANGE HEALTHCARE