VERMONT

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

~Asthma: Immunologic Therapies~
Prior Authorization Request Form

In order for members to receive Medicaid coverage for medications that require prior authorization, the prescriber must 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: _____
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#_____ Please

check box if this drug is being provided under the DVHA's 340B Drug program and requires the TB modifier ☐

- Patient diagnosis: moderate to severe persistent asthma ☐ severe persistent asthma ☐
  Chronic idiopathic urticaria (Xolair only) ☐
- Is the member currently smoking? YES☐ No ☐ Quit Date (if applicable) _____
- Is the prescriber an allergist, immunologist, or pulmonologist: **NO** ☐ **YES** ☐
- Medication from each of the following classes must have been tried and failed prior to consideration (Antihistamine trial only required for diagnosis of Chronic idiopathic urticaria):

Therapy:	Specific Drug:	Reason for discontinuation:	Date:
Inhaled Corticosteroid (ICS):	_____	_____	_____
Leukotriene Receptor Antagonist (LTRA):	_____	_____	_____
Long-Acting Beta Agonist (LABA):	_____	_____	_____
H1 Antihistamine (at double daily dose)	_____	_____	_____

☐ **Xolair** Dose: _____ Frequency: _____

- Positive test to perennial aeroallergen by a skin or blood test: **NO** ☐ **YES** ☐, Aeroallergen: _____
- IgE level ≥ 30 and ≤ 700 IU/ml (ages 12 and older) or ≥ 30 and ≤ 1300 (ages 6 to 11) prior to beginning therapy with Xolair: **NO** ☐ **YES** ☐
- IgE Level:_____ Date obtained:_____

☐ **Cinqair** ☐**Dupixent** ☐ **Fasenra** ☐ **Nucala** Dose: _____ Frequency: _____

- Pre-treatment FEV1 < 80% predicted: **NO** ☐ **YES** ☐

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- 2 or more exacerbations in the previous year despite use of maintenance therapies listed above: **NO** ☐ **YES** ☐
- Eosinophilic phenotype as defined by pre-treatment blood eosinophil count: **NO** ☐ **YES**
- Eosinophil Count: _____Date obtained: _____

Renewal Requests (Clinical notes documenting member's response to therapy must be submitted):

- Has the patient continued to receive therapy with an ICS and either a LABA or LTRA? **NO** ☐ **YES** ☐
- Does the patient have documented improvement in FEV1 from baseline? **NO** ☐ **YES** ☐
- Does the patient have a decreased frequency of exacerbations or hospitalizations? **NO** ☐ **YES** ☐
- Is there documented evidence of a decreased dose/frequency of oral steroid requirements? **NO** ☐ **YES** ☐
- Is there documented evidence of a decreased dose/frequency of rescue medications? **NO** ☐ **YES** ☐

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.

Prescribers Signature: Date:

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