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

~Bone Resorption Inhibitors Injectable~
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: _____
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** ☐

Drug requested: ☐ Boniva IV ☐ Evenity ☐ Forteo ☐ Ibandronate IV ☐ Prolia ☐ Miacalcin ☐ Reclast ☐ Xgeva ☐ Zoledronic Acid ☐ Zometa

Dose & Frequency**:** _____

Diagnosis/indication:

☐ Treatment of postmenopausal osteoporosis ☐ Treatment of male osteoporosis

☐ Paget's disease ☐ Treatment of glucocorticoid induced osteoporosis

☐ Bone metastases from solid tumors (tumor type: _____)

☐ Other (please Explain) _____

Has the member previously tried the following preferred medication?

Drug :	**Response:**
Alendronate Oral	☐ side- effect ☐ treatment failure* dates of use_____

***Treatment failure is defined as documented continued bone loss or fracture after one or more years despite treatment with the bisphosphonate.

Prescriber 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