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

~General~

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#______________

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

1. Drug Requested: ____

   Strength/Route/Frequency:____ Length of Therapy:__________________

2. Patients diagnosis for use of this medication: ____

3. Previous history of a medical condition, allergies or other pertinent medical information, that necessitates the use of this medication: ____

4. Was patient seen by any other provider for this condition? YES/ NO What specialty? ___________________________

5. Please list preferred medications previously tried and failed for this condition (clinical notes or other records may be requested if medication trials cannot be located in the member's claims history):

Name of medication	Reason for failure	Date
______________________	______________________________	_________________________________
______________________	______________________________	_________________________________
______________________	______________________________	_________________________________

6. Please list pertinent laboratory test(s) or procedure(s) if applicable:

Procedure	Finding	Date
______________________	______________________________	________________________________

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.

Prescribers Signature: Date: