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

~General Specialty ~

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 ☐

Patient Diagnosis: ____

Drug Name/Strength: ____

Sig. Dose: _______________________**Route:** _______________________ **Frequency:** ____________________________

Qty: ___________________________ **Refill X:** _______________________ **Length of therapy**: ______________________

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

Was patient seen by any other provider for this condition? ☐ Yes ☐ No

Specialist name: ________________________________ Specialist Type: _____________________________________

Medications previously tried and failed for this condition:

Name of medication	Type of failure	Date
________________________	_________________________________	_______________
________________________	_________________________________	_______________
________________________	_________________________________	_______________

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

Procedure/Test	Finding	Date
_________________________	____________________________________	____________
_________________________	____________________________________	____________

Other Information/comments: ____

____

Deliver product to: ☐ Patient's home ☐ MD office ☐ Clinic

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's Signature: ____ **Date:** ____________________________