VERMONT

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

Prior Authorization Request Form

Vermont Medicaid has established coverage limits and criteria for prior authorization of Remicade. In order for beneficiaries to receive Medicaid coverage for Remicade, it will be necessary for the prescriber to complete and fax this prior authorization request 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: _____
Phone#:_____
Fax#: _____
Address: _____
Contact Person at Office: _____

Beneficiary:

Name: _____
Medicaid ID#:_____
Date of Birth: _____ **Sex:** _____
Pharmacy Name_____
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** ☐

		Dosage			
Drug Brand Name	**Strength**	**Instructions**	**Quantity**	**Days Supply**	**Refills**
REMICADE	_____	_____	_____	_____	1 2 3 4

Indication: ☐ Crohn's Disease ☐Ulcerative Colitis ☐ Rheumatoid Arthritis ☐ Ankylosing Spondylitis

☐Psoriasis (Plaque) ☐ Psoriatic Arthritis

List previous medications tried and failed for this condition:

Name of medication	Reason for failure	Date (s) attempted
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please explain why self-injectables (if indicated but not trialed) cannot be trialed?

_____

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