

Preferred Drug List Prior Authorization Form



West Virginia Medicaid
Drug Prior Authorization Form

<http://www.dhhr.wv.gov/bms/Pharmacy/Pages/default.aspx>

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Patient Name (Last)	(First)	(M)	WV Medicaid 11 Digit ID#	Date of Birth (MM/DD/YYYY)
<input style="width: 95%;" type="text"/>				

Prescriber Name (Last)	(First)	(MI)	
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	
Prescriber Address (Street)	(City)	(State)	(Zip)
<input style="width: 95%;" type="text"/>			
Prescriber 10-Digit NPI#	Phone # (111-222-3333)	Fax # (111-222-3333)	
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	

Pharmacy Name (if applicable)			
<input style="width: 95%;" type="text"/>			
Pharmacy Address (Street)	(City)	(State)	(Zip)
<input style="width: 95%;" type="text"/>			
Pharmacy 10-Digit NPI#	Phone # (111-222-3333)	Fax # (111-222-3333)	
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	

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Important Notes: Preauthorization for medical necessity does not guarantee payment.
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Drug Name	Strength	Route of Administration
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Directions	Diagnosis	ICD Diagnosis Code (if available)
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Has the patient experienced treatment failure with the preferred product(s)? If yes, list or explain. If no, further comment is optional. Yes No

Does the patient have a condition that prevents the use of the preferred product(s)? If yes, list the condition(s). If no, further comment is optional. Yes No

Is there a potential drug interaction with the patient's current medication and the preferred product(s)?
If yes, list the condition(s). If no, further comment is optional.

Yes No

Has the patient experienced intolerable side effects while on the preferred product(s)?
If yes, list the condition(s). If no, further comment is optional.

Yes No

Attestation: Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

Check here for electronic signature

Prescriber of Pharmacist Signature

Date:
(MM/DD/YYYY)