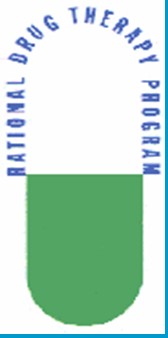
General Drug Prior Authorization Form

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)

Prescriber Name (Last) (First) (MI)

Prescriber Address (Street) (City) (State) (Zip)

# 

West Virginia

Prescriber 10-Digit NPI# Phone # (111-222-3333) Fax # (111-222-3333)

Pharmacy Name (if applicable)

Pharmacy Address (Street) (City) (State) (Zip)

# 

West Virginia

Pharmacy 10-Digit NPI# Phone # (111-222-3333) Fax # (111-222-3333)

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for the return or destruction of these documents. Thank you.

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

Directions Diagnosis ICD Diagnosis Code (if available)

# 

Previous Treatment History

Other Pertinent Information.

**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 or Pharmacist Signature

Date: (MM/DD/YYYY)