

# General Drug Prior Authorization Form



West Virginia Medicaid  
Bureau for Medical Services

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) (Credentials)

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

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

Pharmacy Name (if applicable)

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

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

**Confidentiality Notice:** This document contains confidential health information that is protected by law. This information is intended only for the use of the individual or entity named above. The intended recipient of this information should destroy the information after the purpose of its transmission has been accomplished or is responsible for protecting the information from any further disclosure. The intended recipient is prohibited from disclosing this information to any other party unless required to do so by law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately by telephone at (800) 847-3859 and arrange 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 Duration (if applicable) 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)