

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)

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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	Duration (if applicable)	Route of Administration
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Directions	Diagnosis	ICD Diagnosis Code (if available)
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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.

Prescriber or Pharmacist Signature

Date:
(MM/DD/YYYY)

Check here for
electronic signature