

Home Infusion Therapy 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.

Primary Diagnosis ICD Diagnosis Code (if available)

Secondary Diagnosis ICD Diagnosis Code (if available)

One therapy per form; list components:

Drug Name and Strength NDC Number Total Quantity (for entire course)

Directions Doses per Day Route of Administration

Start Date:

Duration:

End Date:

Dispense Type: Bag Syringe Cassette Other

Clinical Justifications (antibiotics require C&S Report)

Justification for use of non-oral treatment:

Other pertinent information (attach additional pages if needed)

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)

For Internal Use Only

Compounding Code:

Quantity

Duration

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Reviewed by:

Date:

Status:

Notes/Comments

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