Antifungal Drug Prior Authorization Form

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

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
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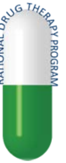

Patient Name (Last) | (First) | (M) | WV Medicaid 11 Digit ID# | Date of Birth (MM/DD/YYYY)

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 | Route of Administration

Directions | Diagnosis | ICD Diagnosis Code (if available)

Is the patient immunocompromised?	Yes	No
If Yes, please describe the condition the patient has that is decreasing his/her immune function.		
Is this medication being prescribed to treat an active fungal infection or to prevent a fungal infection?	Treatment	Prevention
If this medication is being prescribed to prevent a fungal infection, please justify antifungal prophylaxis in this patient, in detail.		
Please document the anatomic location (i.e. the affected areas) of the infection.		

Updated 3/8/2026

If the diagnosis is onychomycosis or tinea unguium, please attach the fungal culture & sensitivity or KOH test results that confirmed the diagnosis.
If the patient has previously attempted therapy with any other antifungal medication(s) for this condition, please list and describe. Please include the medication name, strength, directions, date range, and results for each trial.
Please include any other pertinent information below. If a fungal culture & sensitivity report was performed for this infection, please also attach the results.

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)