Preferred Drug List Prior Authorization Form

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

Prescriber Name (Last)	(First)	(MI)

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)

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)

Has the patient experienced treatment failure with the preferred product(s)? **O Yes O No**
If yes, list or explain. If no, further comment is optional.

Does the patient have a condition that prevents the use of the preferred product(s)? **O Yes O No**
If yes, list the condition(s). If no, further comment is optional.

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Is there a potential drug interaction with the patient's current medication and the preferred product(s)? If yes, list or explain.. If no, further comment is optional.	**O Yes O No**
Has the patient experienced intolerable side effects while on the preferred product(s)? If yes, list or explain.. If no, further comment is optional.	**O Yes O No**
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.	O **Check here for electronic signature**
Prescriber or Pharmacist Signature:	Date: (MM/DD/YYYY)