

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)	
<p><small>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 (877) 215-4100 and arrange for the return or destruction of these documents. Thank you.</small></p>			
<p>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.</p>			
Drug Name	Strength	Route of Administration	
Directions	Diagnosis	ICD Diagnosis Code (if available)	
Has the patient experienced treatment failure with the preferred product(s)? <small>If yes, list or explain. If no, further comment is optional.</small>			<input type="radio"/> Yes <input type="radio"/> No
Does the patient have a condition that prevents the use of the preferred product(s)? <small>If yes, list the condition(s). If no, further comment is optional.</small>			<input type="radio"/> Yes <input type="radio"/> No

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Is there a potential drug interaction with the patient's current medication and the preferred product(s)?

Yes No

If yes, list or explain.. If no, further comment is optional.

Has the patient experienced intolerable side effects while on the preferred product(s)?

Yes No

If yes, list or explain.. If no, further comment is optional.

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)