

<http://www.dhhr.wv.gov/bms/Pharmacy/Pages/default.aspx>

Patient Name (Last)	(First)	(M)	WV Medicaid 11 Digit ID#	Date of Birth (MM/DD/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Prescriber Name (Last)	(First)	(MI)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Prescriber Address (Street)	(City)	(State)	(Zip)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Prescriber 10-Digit NPI#	Phone # (111-222-3333)	Fax # (111-222-3333)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Pharmacy Name (if applicable)
<input type="text"/>

Pharmacy Address (Street)	(City)	(State)	(Zip)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Pharmacy 10-Digit NPI#	Phone # (111-222-3333)	Fax # (111-222-3333)
<input type="text"/>	<input type="text"/>	<input type="text"/>

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.

Drug Name	Strength	Route of Administration
<input type="text"/>	<input type="text"/>	<input type="text"/>
Directions	Diagnosis	ICD Diagnosis Code (if available)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Does the patient have a diagnosis of relapsing multiple sclerosis (MS)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No - Not Approved
Has the patient had a trial of the preferred first-line agent for multiple sclerosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No - Not Approved
Does the patient have a negative tuberculin skin test prior to the initiation of therapy?	<input type="checkbox"/> Yes - Provide results with request	<input type="checkbox"/> No - Not Approved
Are there transaminase and bilirubin levels taken within six months of the requested start date of therapy?	<input type="checkbox"/> Yes - Provide results with request	<input type="checkbox"/> No - Not Approved
Will you report measurements of the ALT monthly for at least the first six (6) months of therapy? (The first two months may be reported simultaneously)	<input type="checkbox"/> Yes - Results will be forwarded	<input type="checkbox"/> No - Not Approved
Will there be a complete blood cell count (CBC) within six (6) months of initiation of therapy? If so, will those results be forwarded?	<input type="checkbox"/> Yes	<input type="checkbox"/> No - Not Approved
For Female patients: Is there a negative pregnancy test prior to the initiation of therapy?	<input type="checkbox"/> Yes - Provide results with request	<input type="checkbox"/> No - Not Approved
For Female patients: Is the patient established on a reliable method of contraception?	<input type="checkbox"/> Yes - Provide details with request	<input type="checkbox"/> No - Not Approved
Is the patient between eighteen (18) and sixty-five (65) years of age?	<input type="checkbox"/> Yes	<input type="checkbox"/> No - Not Approved

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.

Check here for electronic signature

Prescriber or Pharmacist Signature

Date:
(MM/DD/YYYY)