

# Continuation of Hepatitis-C Therapy Prior Authorization Form

West Virginia Medicaid  
Drug Prior Authorization Form

(to be used for Continuation of Therapy only)

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

<http://www.dhhr.wv.gov/bms/BMS%20Pharmacy/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)	Prescriber Specialty
<input type="text"/>	<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"/>

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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.

## Continuation of Hepatitis-C Therapy

### Current Regimen and Duration

<input type="text"/>		
Date Therapy Initiated	TW4 Viral Load (Documentation must be included)	Date Viral Load Obtained
<input type="text"/>	<input type="text"/>	<input type="text"/>

Other pertinent information (attach additional pages if needed).

<input type="text"/>
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**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 Signature	<input type="text"/>	Date: (MM/DD/YYYY)	<input type="text"/>
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