

Antifungal Drug Prior Authorization Form



West Virginia Medicaid
Drug Prior Authorization Form
<http://www.dhhr.wv.gov/bms/Pharmacy/Pages/default.aspx>

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

Patient Name (Last)	(First)	(M)	WV Medicaid 11 Digit ID#	Date of Birth (MM/DD/YYYY)
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Prescriber Name (Last)	(First)	(MI)
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Prescriber Address (Street)	(City)	(State)	(Zip)
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Prescriber 10-Digit NPI#	Phone # (111-222-3333)	Fax # (111-222-3333)
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Pharmacy Name (if applicable)
<input style="width: 95%;" type="text"/>

Pharmacy Address (Street)	(City)	(State)	(Zip)
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Pharmacy 10-Digit NPI#	Phone # (111-222-3333)	Fax # (111-222-3333)
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" 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.

Drug Name	Strength	Route of Administration
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Directions	Diagnosis	ICD Diagnosis Code (if available)
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Duration of Treatment: <input style="width: 95%;" type="text"/>	Site of Infection: <input style="width: 95%;" type="text"/>
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1. Does the Patient have or need to prevent a systemic fungal infection? Yes (Explain) No (Go to Question 2)

Identify Organism

2. Does the patient have a diagnosis of onychomycosis confirmed with a positive KOH test or culture and another co-morbid condition of diabetes, HIV, cancer, organ transplantation, or is otherwise immunocompromised? Yes (Explain) No

3. Can the patient be treated with a topical antifungal product?

Yes

No (Explain)

Previous Treatment History

Other Pertinent Information (attach additional pages if needed)

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)