

# Home Infusion Therapy 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"/>

**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.

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

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

One therapy per form; list components:

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

Directions	Doses per Day	Route of Administration
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Duration:	Start Date:
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
	End Date:
	<input style="width: 95%;" type="text"/>

Dispense Type:  Bag  Syringe  Cassette  Other

**Clinical Justifications** (antibiotics require C&S Report)

**Justification for use of non-oral treatment:**

**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 of Pharmacist Signature  Date:   
(MM/DD/YYYY)

**For Internal Use Only**

Compounding Code:

Quantity

Duration

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Reviewed by:  Date:  Status:

Notes/Comments