COX-2 Inhibitors 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)

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)

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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

Directions | Diagnosis | ICD Diagnosis Code (if available)

Question		
Is the COX-2 Inhibitor prescribed for a chronic condition?	☐ Yes - proceed to next question	☐ No - request is not approved
Is the patient seventy (70) years of age or older?	☐ Yes	☐ No - proceed to next question
Is the patient currently on anticoagulation therapy?	☐ Yes	☐ No - proceed to next question
Does the patient have a history of or risk for a serious GI complication? (GERD is not considered a serious GI complication.)	☐ Yes - please explain below	☐ No - request is not approved

☐ Barrett's esophagus ☐ GI Bleed ☐ Other

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) ____________