Tobacco Cessation Extension (beyond 90 days) Prior Authorization Form



West Virginia Medicaid Drug Prior Authorization Form

 $\underline{\text{http://www.dhhr.wv.gov/bms/Pharmacy/Pages/default.aspx}}$

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 D	Pigit ID#	Date of Birth (MM/DD/YYYY)
Prescriber Name (Last)		(First)			(MI)
Prescriber Address (Street)		(City)		(State)	(Zip)
				West Virginia	a
Prescriber 10-Digit NPI#	Phone # (111-222-3333	3)	Fax # (111	-222-3333)	
Pharmacy Name (if applicable)					
Pharmacy Address (Street)		(City)		(State)	(Zip)
		,		West Virginia	a
L Prescriber 10-Digit NPI#	 Phone # (111-222-3333	L	 Fax # (111	-222-3333)	
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recipient of this information should destroy the information after recipient is prohibited from disclosing this information to any of action taken in reliance on the contents of these documents is for the return or destruction of these documents. Thank you. Important Notes: Preauthorization for medical necessity The use of pharmaceutical samples with the pharmacologic therapy the patient.	ther party unless required to do so by I strictly prohibited. If you have received does not guarantee payment. Il not be considered when evaluating the	aw. If you are not the intend this information in error, pla the members' medical condition	ed recipient, you are her ease notify the sender in on or prior prescription h	eby notified that any onediately by telephonediately by telephonediately for drugs that research	disclosure, copying, distribution, or ne at (800) 847-3859 and arrange equire prior authorization.
of each titration step.					
Document the pharmacologic therapy preso duration of each titration step.	cribed for this patient to co	mplete the current o	quit attempt, inclu	uding the dose,	directions, and
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Provide a brief description of the effectiveness of the pharmacologic therapy prescribed for the current quit attempt thus far.					
Provide the reason an extended	d course of therapy is required for this patient to successfully quit tobacco.				
Provide a brief assessment of th	ne patient's readiness to quit tobacco.				
Attestation: Your signature (man exceed the medical needs of the rmade available upon request.	ually or electronically) certifies that the above request is medically necessary, does not nember, and is documented in your medical records. Medical/Pharmacy records must be	Check here for electronic signature			
Prescriber of Pharmacist Signature	Date: (MM/DD/YYYY)				