West Virginia Medicaid
Drug Prior Authorization Form

http://www.dhhr.wv.gov/bms/Pharmacy/Pages/default.aspx

Aubagio® (terflunomide) Prior Authorization Form

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) West Virginia | (Zip)

Prescriber 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Pharmacy Name (if applicable)

Pharmacy Address (Street) | (City) | (State) West Virginia | (Zip)

Pharmacy 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

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.

Drug Name | Strength | Route of Administration

Directions | Diagnosis | ICD Diagnosis Code (if available)

Does the patient have a diagnosis of relapsing multiple sclerosis (MS)?	☐ Yes	☐ No - Not Approved
Has the patient had a trial of the preferred first-line agent for multiple sclerosis?	☐ Yes	☐ No - Not Approved
Does the patient have a negative tuberculin skin test prior to the initiation of therapy?	☐ Yes - Provide results with request	☐ No - Not Approved
Are there transaminase and bilirubin levels taken within six months of the requested start date of therapy?	☐ Yes - Provide results with request	☐ No - Not Approved
Have there been measurements of ALT monthly for at least the six (6) months leading up to the start of therapy?	☐ Yes - Provide results with request	☐ No - Not Approved
Will there be a complete blood cell count (CBC) within six (6) months of initiation of therapy? If so, will those results be forwarded?	☐ Yes	☐ No - Not Approved
For Female patients: Is there a negative pregnancy test prior to the initiation of therapy?	☐ Yes - Provide results with request	☐ No - Not Approved
For Female patients: Is the patient established on a reliable method of contraception?	☐ Yes - Provide details with request	☐ No - Not Approved
Is the patient between eighteen (18) and sixty five (65) years of age?	☐ Yes	☐ No - Not Approved

Previous Treatment History

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)