

**West Virginia Department of Health and Human Resources  
Division of Tuberculosis Elimination  
PRIOR AUTHORIZATION FOR TB TESTING**

County: \_\_\_\_\_ Date: \_\_\_\_\_ Requesting TST: \_\_\_\_\_ Requesting T-SPOT: \_\_\_\_\_

Narrative: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Risk Assessment submitted? (Required for review) Yes \_\_\_ No \_\_\_

Other documentation submitted? Yes \_\_\_ No \_\_\_ # of pages \_\_\_\_\_

Nurse signature: \_\_\_\_\_  
\_\_\_\_\_

Response/Recommendation from WV-DTBE:

Need additional information: \_\_\_\_\_

Please send \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

May obtain state funded TST: \_\_\_\_\_ May obtain state funded T-SPOT: \_\_\_\_\_

May not obtain state funded TST: \_\_\_\_\_ May not obtain state funded T-SPOT: \_\_\_\_\_

Narrative: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WV-DTBE staff: \_\_\_\_\_ Date: \_\_\_\_\_