WVCHIP
WV Children's Health Insurance Program
Pharmacy Prior Approval Program

PO Box 9511 HSCN, WVU School of Pharmacy
Morgantown, WV 26505
Phone 1-800-847-3859 **FAX: 1-800-531-7787**

Prior Approval Request Form

I. Patient and Medication Information

Patient Name (Last) (First) (MI)	**Patient's WVCHIP Identification #:**	**Patient's Date of Birth**
Requested Medication Name:	**Dose**	**Directions**
Primary Diagnosis for use of this drug:	(Optional) Diagnosis Code (ICD-9-CM)	
Secondary Diagnoses of Concern:		

II. Prescriber Information

Prescribing Practitioner's Name (Last)	(First)	(MI)	(Specialty)
Practitioner Address: (Street)	(City)	(State)	(Zip)
Practitioner DEA Number	Return Phone #	Return FAX #	

III. Pharmacy Information (if known)

Dispensing Pharmacy NABP Number	Return Phone #	Return FAX #	
Pharmacy Name:			
Pharmacy Address: (Street)	(City)	(State)	(Zip)

Please answer each of the following questions for your request.

1. Has the patient been treated for the same diagnosis with other medication(s)? ☐ Yes ☐ No
If Yes, please list the agents this patient has failed and the dates when they failed them.

2. Are there therapeutic reasons that prevent the user of other medication(s) that no not require a PA? ☐ Yes ☐ No
If Yes, list the condition(s), if No, list the reason why the other medication cannot be used.

Practitioner Signature: _____
(If a signature stamp is used, then the prescribing Practitioner must initial the signature, signatures by agents of the Practitioner are not acceptable)

CONFIDENTIAL INFORMATION