



**WV Public Employees Insurance Agency
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 PEIA 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)		

IV. Please answer each of the following questions for your request.

- 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.

- Are there therapeutic reasons that prevent the use of other medication(s) that do not require PA? Yes No
If YES, list the conditions(s), if NO, list the reason why the other medication can not 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)

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