

WEST VIRGINIA BUREAU FOR MEDICAL SERVICES

HOME INFUSION THERAPY

PRIOR AUTHORIZATION REQUEST FORM

FAX:800-531-7787 Phone:800-847-3859

***NOTE: Form must be completed in entirety before prior approval can be granted

Section I:

Pharmacy Name:		Phone: Fax:	
NABP:	Physician Name/DEA#:		
Recipient Name:		Medicaid ID#:	
Primary diagnosis:			
Secondary diagnosis:			

***Justification for use of IV route vs. oral route: _____

Section II: Therapeutic Medication (only one drug therapy per form)

Drug Name/Strength	NDC Number	Number of vials	RDTP Use
a)			
b)			
c)			
Dosage and frequency:			# of bags/day:
Route of Administration: (please check one)			
___ Implanted Venous Device ___ Peripherally Inserted Central Line Catheter (PICC)			
___ Central Line Catheter ___ Peripheral Access Line ___ Subcutaneous Infusion			
___ Other (please explain):			
Duration of therapy:		Start date:	Start time:
		Stop date:	Stop time:

Type of Container Dispensed (Please check one):
<input type="checkbox"/> Bag (gravity type - any bag connected, via tubing to a pump or directly to a patient)
<input type="checkbox"/> Syringe (medication prepared in a syringe for use with IV infusion pump or direct IV injection)
<input type="checkbox"/> Cassette (for reservoir mini-bags (≤ 100 cc) where bag is inserted into an electric pump)
Pole: Infusion Pump Request: Ambulatory, CADD, AVI, Other:

Section III: Flushes

Medication	NDC number	Volume & Frequency (SASH/other)	# of vials	RDTP Use
a)				
b)				

Section IV: _____
Pharmacist's signature
Date

Section V:

FOR RATIONAL DRUG THERAPY PROGRAM (RDTP) USE ONLY		
Authorization/Approval Code		
Approved	Rejected	Pump Authorized Pole Authorized
NDC COMPOUNDING CODE	QUANTITY	DURATION
a)		
b)		
c)		
Approved by	Date:	