Home Infusion Therapy Prior Authorization Form

CoventryCares of West Virginia, Inc.
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Phone: 1-877-215-4100

www.coventrycareswv.com

Patient Name (Last)	(First)	(MI)	WV Medicaid 11-Digit ID #	Date of Birth (MM/DD/YYYY)

Prescriber Name (Last)	(First)	(MI)

Prescriber Address (Street)	(City)	(State)	(Zip)

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

Pharmacy Name (if applicable)

Pharmacy Address (Street)	(City)	(State)	(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 (877) 215-4100 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.

Primary Diagnosis	ICD Diagnosis Code (if available)
Secondary Diagnosis	ICD Diagnosis Code (if available)

One therapy per form; list components:

Drug Name and Strength	NDC Number	Quantity and Description

Directions	Doses Per Day	Route of Administration

Duration

Start Date:

End Date:

Dispense Type

☐ Bag ☐ Syringe ☐ Cassette ☐ Other:

Clinical Justifications (antibiotics require C&S report)

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Justification for use of non-oral treatment:

Other Pertinent Information (attach additional pages)

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)

For Internal Use Only		
Compounding Code	Quantity	Duration
Reviewed by:	Date:	Status:
Notes / Comments:		