



# WELLCARE INJECTABLE INFUSION FORM

Prior Authorization Request for WellCare Medicare/ Prescription Drug Plan (PDP)

FAX to 1-866-388-1767 WellCare Pharmacy - Injectable Infusion Department

Who is making this request?

Provider

Member

Appointed Representatives: Please include a signed Appointment of Representative form (CMS-1696) or equivalent notice.

Complete each section legibly and completely (include any additional necessary medical records or laboratory results)						Date Submitted	
Member ID #			Provider ID#				
Name			Name				
Address						Address	
City		State	Zip		City	State	Zip
Phone			DOB	Contact			
Height	Wt lb/ Kg	Dx		Phone		Fax	
Allergies		ICD9		Alt Phone		Fax	
Medication		Dose		Frequency		Length of Treatment	
Physician Signature:							
Clinical Reason for override (Include medications tried and failed, laboratory values, or any other pertinent information). Please fax additional pages as necessary.							
<p>Does the member reside in a long term care facility (LTC)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Will the medication be sent to the provider's office for administration? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes: Pharmacy is responsible for collecting the medication co-payment/co-insurance from the patient. Drugs <u>Will Not</u> be sent until payment is received.</p> <p>Send to address listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No Send to:</p> <p>Name _____</p> <p>Address _____</p> <p>City, State, ZIP _____ Phone : _____</p> <p>Will physician supply and administer medication in the office ? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes: Physician's office is responsible for collecting medication co-payment/co-insurance from the patient.</p> <p>Is the Medication being administered at the patient's home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the medication being administered at a facility or outpatient center? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Facility Name/Outpatient Clinic: _____ Facility Name/Outpatient Clinic Provider ID#: _____</p>							
<p><input type="checkbox"/> REQUEST FOR EXPEDITED REVIEW (24 HOURS)</p> <p>I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION.</p>							