



WELLCARE INJECTABLE INFUSION FORM

Prior Authorization Request for WellCare Medicare/ Private Fee for Service (PFFS)

FAX to 1-877-277-1809 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							
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.							
Does the member reside in a long term care facility (LTC)? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Will the medication be sent to the provider's office for administration? <input type="checkbox"/> Yes <input type="checkbox"/> No							
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.							
Send to address listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No Send to:							
Name _____							
Address _____							
City, State, ZIP _____ Phone : _____							
Will physician supply and administer medication in the office ? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If Yes: Physician's office is responsible for collecting medication co-payment/co-insurance from the patient.							
Is the Medication being administered at the patient's home? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Is the medication being administered at a facility or outpatient center? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Facility Name/Outpatient Clinic: _____ Facility Name/Outpatient Clinic Provider ID#: _____							
[] REQUEST FOR EXPEDITED REVIEW (24 HOURS)							
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.							