# WELLCARE INJECTABLE INFUSION FORM

Prior Authorization Request for Wellcare of Ohio Medicaid

FAX to **1-877-277-6892** WellCare Pharmacy - Injectable Infusion Department

**Requested by :** ☐ Physician ☐ Member ☐ Pharmacy

| **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 |
|---|---|---|---|
| | | | |
| | | | |
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| | | | |
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**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) ? ☐ **Yes** ☐ **No**

Will the medication be sent to the provider's office for administration? ☐ **Yes** ☐ **No**

**If Yes:** Pharmacy is responsible for collecting the medication co-payment from the patient. Drugs Will Not be sent until payment is received.

Send to address listed above? ☐ **Yes** ☐ **No** Send to:

Name ______________________________________________

Address ______________________________________________

City, State, ZIP ___________________________________ Phone : ___________________________

Will physician supply and administer medication in the office ? ☐ **Yes** ☐ **No**

**If Yes**: Physician's office is responsible for collecting medication co-payment from the patient.

Is the Medication being administered at the patient's home? ☐ **Yes** ☐ **No**

Is the medication being administered at a facility or outpatient center? ☐ **Yes** ☐ **No**

Facility Name/Outpatient Clinic: ______________________________ Facility Name/Outpatient Clinic Provider ID#:__________________

Rev: 09/08

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Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.