



## 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	
Fax all supporting documentation						Physician Signature:				
Document clinical rationale for override/exception request. List all names and doses of previous medication(s) tried/failed. Document all necessary lab values.										
Will physician supply and administer medication in the office ? <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 Send to address listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No Send to: Name _____ Address _____ City, State, ZIP _____ Phone : _____										
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#: _____										