



## WELLCARE INJECTABLE INFUSION FORM

Coverage Determination 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 ?  Yes  No

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

Send to address listed above?  Yes  No Send to:

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_ Phone : \_\_\_\_\_

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#: \_\_\_\_\_