



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

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#: _____

Ohio Department of Job and Family Services
CERTIFICATE OF MEDICAL NECESSITY/ PRESCRIPTION
ENTERAL NUTRITION SERVICES

Medicaid Supplier/Pharmacy Provider Name						Provider NPI and Medicaid Legacy Number					
SECTION A CERTIFICATION TYPE (To be completed by medical supplier/pharmacy provider)											
<input type="checkbox"/> INITIAL Prescription Date _____				<input type="checkbox"/> RECERTIFICATION PA # _____				<input type="checkbox"/> REVISED PA # _____			
Change in prescriber order? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide previous formula and # of calories per day						End date for previous PA Number of units billed					
1. Consumer Name									Consumer Date of Birth		
Note: WIC program provides formula for children age 5 and under.											
2. Is the recipient receiving nutritional supplement(s) from WIC? <input type="checkbox"/> Yes <input type="checkbox"/> No											
If yes, specify product(s) and amount supplied by WIC.						Product(s)			Amount		
SECTION B PRESCRIBER CERTIFICATION/PRESCRIPTION (Must be completed by Prescriber)											
3. Diagnosis(es) [ICD-9 Code and Description]											
4. Does the consumer have an absorption problem, swallowing dysfunction, obstruction or require tube-feeding? If "Yes", explain <input type="checkbox"/> Yes <input type="checkbox"/> No											
5. If you answered "No" to #4, please explain why enteral nutrition is required. List lab values in #7, if applicable.											
6. If you answered "No" to #4, AND the consumer is unable to maintain weight on regular food, provide weight history.											
Date	Current Weight	Height	Date	Weight	Date	Weight	Date	Weight			
7. If you answered "No" to #4, AND lab values indicate nutritional deficiency, please provide all applicable lab results. List name of test, value and date or attach a copy of current lab results.											
8. Length of Need Number of Months _____						Note: Maximum approval period is 12 months. Recertification is required annually.					
9. Prescribed enteral product and calorie requirements. Note: If daily calorie requirements exceed 2000, please explain.											
<u>Product</u>						<u>Calories Per Day</u>					
10. Enteral Administration Supplies (Must Be Completed for Tube Feedings): <input type="checkbox"/> Pump <input type="checkbox"/> Gravity <input type="checkbox"/> Farrell Valve <input type="checkbox"/> Bolus <input type="checkbox"/> Ext. sets											
11. Number of calories per can						12. Number of cans per case					
Prescriber Name (Printed)											
I certify that I am the prescriber identified above. I certify that the information in Sections A and B of this certificate of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that my falsification, omission, or concealment of material fact may subject me to civil or criminal liability.											
Prescriber's Signature (No stamps)									Date		
Prescriber's NPI and Medicaid Legacy Number						Prescriber's Area Code and Phone Number					

Prior Authorization/ Medical Necessity Documentation Requirements

The purpose of these guidelines is to define the written documentation required to assist the department in determining the medical necessity for enteral nutrition. This information, including the order for the specific enteral nutrition product and calorie requirements, must be in the form of a complete and signed physician certificate of medical necessity. Medicaid providers will use the ODJFS "Certificate of Medical Necessity/Prescription, Form JFS 01907 (Rev. 3/2008)" for all enteral nutrition requests.

General Guidelines

- Initial requests for enteral products may be authorized for periods up to 12 months.
- When documenting medical necessity, please be specific when describing the medical need for the enteral nutrition. Avoid using general statements about the patient's health status.
- Always provide the current prior authorization number and authorized date spans when requesting certification or a revision to an existing prior authorization.
- Medical suppliers/pharmacies must complete Section A of the certificate of medical necessity.
- Prescribers must complete Section B of the certificate of medical necessity.

Documentation of Medical Necessity

Documentation of medical necessity must include all applicable diagnoses. Provide the **ICD-9** code and a **written description**; failure to provide both may delay processing of the prior authorization request. In addition to the diagnosis, submit information that supports the need for the nutritional supplement. A diagnosis and brief written description of the consumer's condition will generally be sufficient documentation for those consumers who require tube feedings as their sole source of nutrition, or have a disease/condition that prevents adequate absorption of sufficient nutrition from regular food.

For those consumers who do not meet the aforementioned criteria, documentation must include (in addition to specifying all applicable diagnoses) justification for why the enteral nutrition is required. If a patient cannot maintain weight, provide a weight history documenting the weight loss. Lab values which document nutritional deficiencies (e.g. albumin) should also be provided (general rule-of-thumb: if lab values are available, document them). The certificate of medical necessity **must** specify the daily calorie requirements to be supplied by the enteral product. Note: Please provide an explanation when daily calorie requirements exceed 2000.

WIC

The Women, Infants and Children (WIC) program will cover formula for children ages 0 to 5. Consumers must obtain enteral products for these children from WIC prior to requesting coverage through Medicaid. WIC coverage is limited to a select number of formula products. If WIC does cover the ordered formula, but does not supply the total amount required, Medicaid will consider coverage of the difference. When the ordered formula is not covered by WIC, it may be considered for coverage by Medicaid.

Billing

Use the appropriate alpha-numeric HCPCS code as listed in OAC code 5101: 3-10-03. **Do not use NDC numbers.** Providers are to dispense and bill for authorized enteral products on a **monthly** basis. Payment will be contingent upon recipient eligibility.