



## WELLCARE INJECTABLE INFUSION FORM

Medicare Part D: Fax to **1-866-388-1767** Pharmacy Request

Medicare Part B (Medical): Fax to **1-888-871-0564** Authorization Request

WellCare will evaluate the request based on applicable medical criteria, FDA guidelines, protocols developed by WellCare Pharmacy & Therapeutics Committee, and plan benefits.

**Who is making this request?**  Provider  Member

*Appointed Representatives:* Please include a signed Appointment of Representative Form (CMS-1696) or equivalent notice.

**REQUEST FOR EXPEDITED REVIEW (PART D: 24 HOURS; PART B: 72 HOURS)**

By checking the expedited box, the requestor certifies that applying the standard review timeframe may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Complete each section legibly and completely (include any additional necessary medical records or laboratory results)										Date of Request					
Member ID #					Provider ID/NPI										
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						
Requested Medication Name				Dose				Frequency				Length of Treatment			
(Please use another form if more lines are needed)										<b>Physician Signature:</b>					
Document clinical rationale for override/exception request. List names and doses of previous medication(s) tried and failed. Fax all supporting documentation.															
1. Is the medication being supplied and administered in physician's office? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes, this is a <u>medical</u> benefit request and should be faxed to 1-888-871-0564. Standard timeframe is 14 calendar days.</b>															
2. Will the medication be sent to the provider's office for administration? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes:</b> Pharmacy is responsible for collecting the medication co-payment from the patient.															
3. 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#: _____															
4. Is the Medication being administered at the patient's home? <input type="checkbox"/> Yes <input type="checkbox"/> No															

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