WellCare Health Plans

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 Advocate Complete FIDA (Medicare-Medicaid Plan) 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 ☐ Participant

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					
Participant 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	Dose	Frequency	Length of Treatment

(Please use another form if more lines are needed) **Physician Signature:**

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? ☐ Yes ☐ No
   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.**
2. 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.
3. Is the medication being administered at a facility or outpatient center? ☐ Yes ☐ No
   Facility Name/Outpatient Clinic**:** _____
   Facility Name/Outpatient Clinic Provider ID#:_____
4. Is the Medication being administered at the patient's home? ☐ Yes ☐ No

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

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