



INJECTABLE INFUSION

Prescription Order Form

FAX to: WellCare Pharmacy - Injectable Infusion

Toll Free 1-866-388-1767

To order any injectable or infusion treatment, please provide the following information and attach pertinent medical records and/or labs to justify authorization.

PLEASE WRITE LEGIBLY					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		

Drug or Supply	Dose	Frequency	Length of Treatment

Previous medications that failed (include drug, dose, strength)

Yes **No** Will the drug(s) be sent to the provider's office? If no, then the provider's office will be responsible for collecting the co-pay from the patient. If this is not a replacement of stock, the pharmacy shipping the medication will be responsible for the collecting the co-pay from the patient.

Yes **No** Will the provider/facility be administering the medication?

Is this request being sent by the primary care physician? Or a Specialist?

Is this a Drug Replacement of stock? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, send to: Name _____ Address _____ City, State, Zip _____ Phone _____	Will member pick up at local pharmacy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide: Pharmacy Name _____ Address _____ City, State, Zip _____ Phone _____
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PHYSICIAN SIGNATURE _____

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