



WELLCARE INJECTABLE INFUSION FORM

Prior Authorization Request for WellCare of New York Medicaid
FAX to 1-866-388-1517 WellCare Pharmacy - Injectable Infusion Department

Requested by : Physician Member Pharmacy Appointed Representative

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#: _____

REQUEST FOR EXPEDITED REVIEW (24 HOURS)

I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION.