



WELLCARE INJECTABLE INFUSION FORM

Coverage Determination Request for WellCare of Florida Staywell and HealthEase

FAX to **1-866-825-2884** WellCare Pharmacy - Injectable Infusion Department

WellCare will evaluate the request based on applicable medical criteria, FDA guidelines, protocols developed by the 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.

Please Check One (Not checking a box will indicate a Standard Review)

REQUEST FOR STANDARD REVIEW (72 HOURS)

REQUEST FOR EXPEDITED REVIEW (24 HOURS)

By checking the expedited box, the requestor certifies 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.

Complete each section legibly and completely (include any additional necessary medical records or laboratory results).				Date of Request		
Member Name				Provider Name		
Member ID#				Provider Address		
Member Address				City, State, Zip		
City, State, Zip				Provider Phone		
Phone		DOB		Provider Fax		
Ht/Wt (lb/kg)		Dx		Provider Contact Name		
Allergies		ICD9		Provider ID# / NPI		
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.

Please answer all questions below for a thorough review.

1. Is the medication being administered in physician's office? **Yes** (see A & B below) **No**
 A. 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.
 B. Will physician supply medication? **Yes** **No**
 If Yes: Physician's office is responsible for collecting medication co-payment from the patient.

2. Is the medication being administered at a facility or outpatient center? **Yes** **No**
 Facility/Outpatient Clinic Name: _____ Facility/Clinic Provider ID#: _____

3. Is the medication being administered in patient's home? **Yes** **No**