



**Medical Drug Authorization Request
Drug Prior Authorization Requests Supplied by the Physician/Facility**

Instructions: To ensure our members receive quality care, appropriate claims payment, and notification of servicing providers, please complete this form in its entirety. **Fax completed form to 1-855-677-3915.**

By using this form, the physician (or prescriber) is asking for Medical drug coverage meeting one or both criteria:

1. The drug is being supplied and administered in the physician's office. Provider will bill the health plan directly.
2. The drug is being supplied and administered at a facility or outpatient center. Facility/outpatient center will bill the health plan directly.

Who is making this request? Provider Member Appointed Representative

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

Priority Level	
<input type="checkbox"/> Expedited	<input type="checkbox"/> Standard <input type="checkbox"/> Post-service
Appointed Representative	
Complete the following section ONLY if the person making this request is not the member or prescriber:	
Requestor's Name:	Requestor's Relationship to Member:
Address, City, State, ZIP:	
Requestor's Phone:	
Member	
Member Name:	Member ID#:
Member Address, City, State, ZIP:	
Phone:	DOB:
Ht/Wt (lb/kg):	Allergies: ICD-10:
Requesting Provider	
WellCare Provider ID Number:	NPI Number:





Last Name:		First Name:	
Street Address:		City, State:	ZIP:
Phone Number		Fax Number:	
Provider Type/Specialty:		Name of Requestor:	

Treating Provider/Vendor

Out of Network If Yes, Please Provide Reason:

WellCare Provider ID Number:		NPI Number:	
Last Name:		First Name:	
Street Address:		City, State:	ZIP:
Phone Number		Fax Number:	
Provider Type/Specialty:		Name of Requestor:	

Facility Information

Type: <input type="checkbox"/> Office <input type="checkbox"/> OP Hospital <input type="checkbox"/> Home-Infusion/DME Provider	Tax ID:		
WellCare Provider ID Number:		NPI Number:	
Facility Name:		Phone Number:	Fax Number:
Street Address:		City, State:	ZIP:

Medication/Service Requested

Medication/HCPCS Code (s)	Dose	Visits/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.

