WellCare Health Plans | HERITAGE HEALTH

WELLCARE INJECTABLE INFUSION FORM

Prior Authorization Request for Wellcare of Nebraska

FAX to 1-877-276-9630 WellCare Pharmacy – Injectable Infusion Department

Requested by: ☐ Physician ☐ Member

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

Complete each section legibly and completely (include any additional necessary medical records or laboratory results)		Date of Request:	
Member ID #:		Provider ID#	
Member Name:		Physician NPI:	
Member's DOB:		Physician Name:	
Member Phone:		Contact Name at MD Office:	
Diagnosis of Requested Medication:		Physician Phone:	
Height:	Weight (lb/Kg):	Physician Phone Fax:	
Allergies:		Pharmacy Phone:	Pharmacy Fax:

Requested Medication Name	**Dose**	**Frequency**	**Length of Treatment**

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

Document clinical rationale for request. List all names and doses of previous medication(s) tried and failed. Include all supporting documentation.

1. Is the medication being supplied and administered in physician's office? ☐ Yes ☐ No
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.

http://dhhs.ne.gov/heritagehealth

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