



WELLCARE INJECTABLE INFUSION FORM

Prior Authorization Request for WellCare of Illinois Harmony Medicaid
FAX to 1-866-825-2884 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.