



## WELLCARE INJECTABLE INFUSION FORM

Prior Authorization Request for WellCare of Georgia Medicaid  
 FAX to **1-866-455-6558 WellCare Pharmacy - Injectable Infusion Department**

Requested by :  Physician  Member  Pharmacy

<b>Complete each section legibly and completely (include any additional necessary medical records or laboratory results)</b>						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#: \_\_\_\_\_