



WELLCARE INJECTABLE INFUSION FORM
 Coverage Determination Request for WellCare of Georgia Medicaid
 FAX to **1-866-455-6558** 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.

Complete each section legibly and completely (include any additional necessary medical records or laboratory results).	Date of Request
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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**