



**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 1-855-606-8424.**

**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		
<b>Complete the following section ONLY if the person making this request is not the member or prescriber:</b>		
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 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 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 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.