Wellpoint

Prior Authorization (PA) Form: Medical Injectables

This form and PA criteria may be found by accessing **https://providers.wellpoint.com**.
If the following information is not complete, correct and/or legible, the PA process can be delayed. Use one form per member please.

Member information					
Last name		**First name**			
Wellpoint member ID		**Date of birth**			
Sex (select one)	☐ **Male** ☐ **Female**	**Height**		**Weight**	
Member's place of residence: ☐ Home ☐ Nursing facility		**Administration location:** ☐ Home ☐ Office ☐ Outpatient facility			

Requesting prescriber information					
Last name		**First name**			
NPI		**Tax ID**			
Address		**City**		**State**	
ZIP code	**Phone number**		**Fax number**		
Office contact name		**Contact direct phone number**			
Is the above prescriber also the administering prescriber? ☐ **Yes** ☐ **No (If no, please complete below)**					

Administering prescriber information					
Last name		**First name**			
NPI		**Tax ID**			
Address		**City**		**State**	
ZIP code	**Phone number**		**Fax number**		
Office contact name		**Contact direct phone number**			

Billing facility information			
Facility name		**Facility contact name**	
NPI/tax ID		**DEA/license**	
Phone number		**Fax number**	

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Fax this form to 844-490-4873.
For telephone PA requests or questions, please call 833-707-0868.
Please allow Wellpoint at least 24 hours to review this request

Medication information		
Drug name and strength:	**SIG (dose, frequency, and duration):**	**HCPCS billing code:**
Diagnosis and/or indication:		**ICD code (required):**

Has the member tried other medications to treat this condition? ☐ **Yes,** provide this information in the area to the right. You may be asked to provide supporting documentation such as copies of medical records, office notes, or complete *FDA MedWatch* form. ☐ **No,** explain why not:	**Drug(s) name and strength:**	
	Date range of use:	**SIG (dose and frequency):**
	Did member experience any of the below? ☐ Adverse reaction ☐ Inadequate response ☐ Other Briefly describe the details of the adverse reaction, inadequate response, or other in the space provided below:	

Describe medical necessity for nonpreferred medication(s) or for prescribing outside of FDA labeling:
List all current medications, including dose and frequency:
Other pertinent information:

Diagnostic studies and/or laboratory tests performed
List all tests done within the past 30 days related to the diagnosis for the medication requested.

Labs:			**Diagnostic tests:**		
Test	**Date**	**Result**	**Procedure**	**Date**	**Result**

Prescriber signature (REQUIRED): _____ Date: _____
(By signature, the prescriber confirms the above information is accurate and verifiable by patient records and understands that any falsification, omission, or concealment of material may be subject to civil or criminal liability.)

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