Prior Authorization Form: Medical Injectables

West Virginia | Mountain Health Trust

This prior authorization (PA) form and PA criteria is available at provider.wellpoint.com/wv.
If the following information is not complete, correct, or legible, the PA process may be delayed.

Requests may be submitted via the ICR at Availity.com.* Please complete **all** required fields, including TIN.

Use one form per member. Fax this form to **844-487-9290**. If you have telephone PA requests or questions, please call **877-375-6185**.

Member information		
Last name:	First name:	
Member ID number:	DOB:	
Required		
Gender: ☐Male ☐ Female	Height:___Weight:___	
Member's place of residence: ☐ Home ☐ Nursing facility		
Administration location: Home Office Outpatient facility		
Requesting provider ☐ Contracted ☐ Noncontracted (Complete the below box if individual provider is *not* billing.)		
Last name:	First name:	Specialty:
NPI number:	Tax ID number:	
Office contact name:	Office phone:	Office fax:
Address:	City, state, and ZIP code:	
Servicing provider ☐ Contracted ☐ Noncontracted (Complete the below box if individual provider is billing.)		
Last name:	First name:	Specialty:
NPI number:	Tax ID number:	
Office contact name:	Office phone:	Office fax:
Address:	City, state, and ZIP code:	

* Availity, LLC is an independent company providing administrative support services on behalf of Wellpoint.

Servicing facility ☐ Contracted ☐ Noncontracted (Complete the below box if the facility is billing.)		
Facility name:		
NPI number:	Tax ID number:	
Facility contact name:	Facility phone:	Facility fax:
Address:	City, state, and ZIP code:	

Medical information		
Drug name and strength requested:		
SIG (dose, frequency and duration):		
HCPCS billing code(s):	ICD code :	
Diagnosis and/or indication:		
Has member tried other medications to treat this condition? ☐ Yes, provide this information in the area below. 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 name and strength requested	Date range of use:	SIG (dose, frequency and duration):
Did member experience any of the below? ☐ Adverse reaction ☐ Inadequate response ☐ Other Briefly describe details of 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 that are related to diagnosis for medication requested.)**					
Labs:			**Diagnostic tests:**		
Test	**Date**	**Result**	**Test**	**Date**	**Result**

Please attach any pertinent medical records required for review.