Select Health Plan:

- ❑ HealthEase
- ❑ Harmony
- ❑ Staywell
- ❑ WellCare (Part B or D)

INJECTABLE INFUSION

Prescription Order Form

FAX to: WellCare Pharmacy - Injectable Infusion
Toll Free 1-866-825-2884

To order any injectable or infusion treatment, please provide the following information and attach pertinent medical records and/or labs to justify authorization.

PLEASE WRITE LEGIBLY						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		

Drug or Supply	Dose	Frequency	Length of Treatment

Previous medications that failed (include drug, dose, strength)

☐ **Yes** ☐ **No** **Will the drug(s) be sent to the provider's office?** If no, then the provider's office will be responsible for collecting the co-pay from the patient. If this is not a replacement of stock, the pharmacy shipping the medication will be responsible for the collecting the co-pay from the patient.

☐ **Yes** ☐ **No** **Will the provider/facility be administering the medication?**

☐ **Is this request being sent by the primary care physician?** ☐ **Or a Specialist?**

Is this a Drug Replacement of stock? ☐**Yes** ☐ **No**
If yes, send to:
Name ____
Address ____
City, State, Zip _____________________________________
Phone ____

Will member pick up at local pharmacy? ☐**Yes** ☐ **No**
If yes, please provide:
Pharmacy Name______________________________________
Address ____
City, State, Zip______________________________________
Phone ____

PHYSICIAN SIGNATURE ______________________________

WE DO NOT ACCEPT THIRD PARTY REQUESTS FILLED OUT OR SENT IN BY PHARMACIES OR PATIENTS.

For Internal Use Only

FAX to: WellCare Pharmacy **Toll Free 1-866-825-2884**

Instructions for submitting an Injectable Order Form (DER Request):

Please fill out the **ENTIRE FORM** and make copies for future use. WE DO NOT ACCEPT THIRD PARTY REQUESTS. Fax the form and any supporting documentation back to the number listed at the top of the form. The forms can also be mailed to the below listed address. Please be aware that normal processing time is 72 hours (business hours) from the time that we receive the form.

If the patient is receiving the medication in the doctor's office please make sure to note this on the form. If the doctor is providing the medication please make sure to note this on the form also. Please do not use J-codes-write the actual names of the medications. Please make sure to include CURRENT labs (within 30 days if pertinent to medication), medical history, or any other medical documentation because the P/A can be denied for lack of medical documentation.

If you have any questions please do not hesitate to call us at 813-290-6200 ext. 4083 (injectable department) or toll-free 1-877-647-7473, (TTY users call 1-888-816-5252) Monday – Friday 7:00 a.m. – 10:30 p.m. EST.

Mailing Address:
Wellcare Health Plans
P.O. Box 25858
Tampa, FL 33622-5858