

## Prior Authorization Form: Medical Injectables

This form and prior authorization (PA) criteria may be found by accessing <https://provider.wellpoint.com/nj>. 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	Member ID	Date of birth
<b>Required</b>			
Member's place of residence: <input type="checkbox"/> Home <input type="checkbox"/> Nursing facility		Height	Weight
Administration site: <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Outpatient facility		<input type="checkbox"/> Male <input type="checkbox"/> Female	

### Prescriber information

Last name	First name	NPI (required)	Tax ID
Phone number		Fax number	

### Prescriber information/demographics

Address where service was rendered		City
State	ZIP code	Telephone number
Office contact name		
Is the above address also the billing address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, please complete below)		

### Billing facility information

Facility name	NPI/tax ID (required)	DEA/license
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### Contact person for billing facility

Last name	First name
Phone	Fax

**Continued on page 2 (required)**

Fax this form to **844-509-9865**.

For telephone PA requests or questions, please call **800-454-3730**.

Please allow Wellpoint at least 24 hours to review this request.

**Medication information**

Drug name and strength requested:	SIG: (dose, frequency and duration)	HCPCS billing code
Diagnosis and/or indication:		ICD-10 code (required):

Has the member tried other medications to treat this condition?  <input type="checkbox"/> <b>Yes</b> , 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. A completed <i>FDA MedWatch Form</i> .  <input type="checkbox"/> <b>No</b> , explain why not:	Drug name(s) and strength:	
	Date range of use:	SIG code: (dose and frequency)
	Did the member experience any of the below? <input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> 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:

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List all current medications including dose and frequency:

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Other pertinent information:

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**Diagnostic studies and/or laboratory tests performed (List all tests done within the past 30 days that are related to diagnosis of medication requested.)**

Labs			Diagnostic tests		
Test	Date	Result	Procedure	Date	Result

**Signature**

Prescriber's signature (required)

Date

**By signing, 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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