Wellpoint

Prior Authorization (PA) Form: Medical Injectables

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 ID number **Date of birth** – –

Member information
****REQUIRED****
☐ **Male** ☐ **Female** **Height** _____ **Weight** _____ **Member's place of residence:** ☐ Home ☐ Nursing facility
Administration location: ☐ Home ☐ Office ☐ Outpatient facility ☐ Hospital
Is the patient currently hospitalized? ☐ Yes ☐ No

Prescriber information

Last name **First name**

NPI # **Tax ID #**

Phone **Fax**

Prescriber information/demographics		
Address where service rendered:	**City:**	**State:**
ZIP code:	**Office contact name:**	**Contact direct phone number:**
Is the above address also the billing address? ☐ **Yes** ☐ **No (If no, please complete below.)**		

Billing facility information

Facility name

NPI # **DEA #**

Contact person for billing facility

Last name **First name**

Phone **Fax**

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

Continued on page 2 (required)

Fax completed form to 844-512-8995.

For telephone PA requests or questions, please call 833-731-2162.

provider.wellpoint.com/tx/

Wellpoint members in the Medicaid Rural Service Area and the STAR Kids program are served by Wellpoint Insurance Company; all other Wellpoint members in Texas are served by Wellpoint Texas, Inc.

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

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 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:

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

LABS:			**DIAGNOSTIC TESTS:**		
TEST	**DATE**	**RESULT**	**PROCEDURE**	**DATE**	**RESULT**

(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.)

Prescriber signature (REQUIRED):		Date:	

Once complete, fax this form to 844-512-8995.
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