Request for Prior Authorization- Medical Injectables

WellFirst Health Plan is your partner in providing care.
In order to efficiently process your authorization request, the information below must be completed.

Member Information:

*Full Name: ____

Address: ____

Telephone #: (_____)____________________ *DOB: ____/____/____

Primary Insurance Name (COB):________________________________

Primary Insurance ID and effective date #:________________________

Member height ________________________

Member weight ________________________

Requested Diagnosis Code: ______________________________________

____

Requested J, S or Q Code: ______________________________________

Drug Name and strength: ______________________________________

Directions ____

Requested Number of Units: ______________________ DOS From: ______/_____/______ to _____/_____/______

PLEASE SEND CLINICAL NOTES AND ALL SUPPORTING DOCUMENTATION

Requesting Provider:

Name: ____________________________________

NPI #: ________________TIN#: ________________

AHCCCS ID: ________________________________

Telephone #: _______________________________

Address: ___________________________________

Fax #: _____________________________________

Contact Name/Phone #:______________________

Servicing Provider/Facility:

Name: ____________________________________

NPI #: _____________TIN#:___________________

AHCCCS ID: ________________________________

Telephone #: _______________________________

Address: ___________________________________

Fax #: _____________________________________

Contact Name/Phone #:______________________

Submitted By: ____ (Please Print) Date: ______/____ /_______
(Please Print)

Please submit all supporting documentation and any applicable information with this request form

Pharmacy Department Phone: 608-828-6393
Pharmacy Department Fax : 608-252-0814

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