WellCare
Beyond Healthcare. A Better You.

Standard Drug Request Form

Beneficiary Information

1. Beneficiary Last Name: _____2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender:_____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information –
Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days):

☐ Up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

1. ☐ Failed two preferred drug(s). If only one preferred drug is available, then fail one preferred drug.
   List preferred drugs failed: _____
   1a. ☐ Allergic Reaction 1b. ☐ Drug-to-drug interaction. Please describe reaction: _____
   _____
2. ☐ Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information:
   _____
3. ☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s).
   Please provide clinical information: _____
   _____
4. ☐ Age specific indications. Please give patient age and explain: _____
   _____
5. ☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a general reference: _____
6. ☐ Unacceptable clinical risk associated with therapeutic change. Please explain:

_____
_____

Signature of Prescriber: _____ Date: _____
(Prescriber Signature Mandatory)
I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to **1-800-678-3189** Pharmacy PA Call Center: **1-866-799-5318**