WellCare of North Carolina by Celtic Insurance Company

Prior Authorization Request Form

Save time and complete online CoverMyMeds.com

CoverMyMeds provides real time approvals for select drugs, faster decisions and saves you valuable time!

Or return completed fax to **1.800.977.4170**

I. PROVIDER INFORMATION	II. MEMBER INFORMATION	
Name:	**Name:**	
NPI #:	**Member ID:**	
Office Contact:	**Date of Birth:**	
Phone:	**Height:**	**Weight:**
Fax:	**Medication Allergies:**	
Diagnosis:	**ICD-10:**	

III. DRUG INFORMATION	
Drug name and strength:	**Dosage Form:**
Directions:	**Qty. per day:**
Length of Therapy:	**Expedite/Urgent?** ☐ Yes ☐ No
Exception? ☐ Yes ☐ No	**Therapy Status:** ☐ Initial ☐ Continuation If continuation, provide therapy start date:

IV. MEDICATION HISTORY	
A. Has strength or daily dose changed? ☐ Yes ☐ No	**List Change:**
B. Have you attached test results (HbA1c, genetic results, etc.) to support this request? ☐ Yes ☐ No	

V. ALTERNATIVE/CONJUNCTIVE TREATMENT HISTORY RELATED FOR THIS REQUEST

Drug Name, Strength, Form, and Dosage	Date(s) of Therapy	Reason for Discontinuation (If active, please indicate.)
1.		
2.		
3.		
4.		

NOTE: Must provide medical record evidence indicating prior use of preferred drug(s).

VI. DOCUMENT CLINICAL RATIONALE FOR USE OF MEDICATION

Prescriber Signature:	**Date:**

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. *See, e.g.*, 31 U.S.C. §§ 3729-3733.

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