PRIOR AUTHORIZATION FORM
PHYSICIAN FAX FORM

DO NOT COPY FORMS FOR FUTURE USE – FORMS ARE UPDATED FREQUENTLY
PLEASE SUBMIT ALL RELEVANT CHART NOTES AND LABORATORY RESULTS FOR CONSIDERATION

PO Box 90369
Lakeland FL 33804

Phone: 866-240-2204
Fax: 888-473-7875
www.welldynerx.com

DATE:

TO:

PHONE:

FAX:

FROM: Prior Authorization Department

PHONE: 866-240-2204

FAX: 888-473-7875

COMMENTS: ***Attach progress notes and relevant labs***

Member Name:
Group Name:
DOB:

Member ID:
Group #:
Drug Name:

Please attach progress notes and relevant labs

Please allow 2 hours before calling to confirm receipt of LMN

This transmittal includes this cover page and 2 additional page(s)

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of WellDyne. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

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Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber Name:		
Member/Insurance ID:			NPI:		
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
☐ Check if requesting **brand**	Directions for Use:	
☐ Check if request is for **continuation of therapy**	Qty:	DS:
☐ Check if request is **urgent**	☐ Check to request **priority review**	

Clinical Information (required)

What is the patient's diagnosis?

ICD-10 Code(s): ____________________________________

Is the request for initial or continuing therapy?

☐ **Initial Therapy** ☐ **Continuing Therapy**

INITIAL THERAPY

What medication(s) has the patient tried and failed? Please include medication names, dates of therapy (MM/YY), and patient's response to therapy

CONTINUING THERAPY

Is the patient responding to the current therapy and experiencing benefit (e.g., improvement in symptoms, improvement in QOL, etc.)?

☐ **Yes** ☐ **No**

Date patient started therapy (MM/YY): ____________________________________

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QTY LIMIT REQUESTS

What is the quantity requested per DAY? _______
What is the reason for exceeding the plan limitations? **Select all that apply –**

☐ Titration or loading dose purposes (please include specific titration/loading dose schedule and anticipate duration)
☐ Dose-alternating schedule
☐ Requested strength/dose is not commercially available
☐ Other: ____

Are there other comments or information the prescriber wishes to provide for this review?

____

____

____

Please note: Recent chart notes discussing the patient's diagnosis AND all pertinent lab values or medical tests should be included for review.

This request may be denied unless all required information is received.

Please fax completed form and supporting documentation to 1-888-473-7875

You can also access this form and submit prior authorizations electronically through CoverMyMeds - visit covermymeds.com to use this free service

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