

Medicare Advantage Part B Drug Request Form



Wellmark Advantage Health Plan, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.

Clinical Review Request for Wellmark Advantage Health Plan Members

Attention: - Pharmacy Department

Fax: 1-877-218-0941

Note: This form is for Medicare Advantage Part B Benefit Drugs. To request authorization for drugs covered under the Medicare Part D Pharmacy Benefit, please fax required information to ** 1-855-633-7673**

Date: _____

Instructions: This form may be used by participating physicians and providers to request clinical review for drugs covered under the medical benefit for Wellmark Advantage Health Plan. Complete this form and fax it to 1-877-218-0941 along with supporting clinical documentation. Please contact Care Management at 1-855-673-4225 for any questions.

ALL REQUESTED INFORMATION MUST BE PROVIDED FOR CONSIDERATION FOR COVERAGE. PLEASE TYPE OR PRINT CLEARLY

Step 1: Patient and Physician Information

Patient Information

Name:
DOB:
Weight:
Member ID:
Fax:

Ordering Provider Information

Name:
Specialty:
NPI:
Phone:
Fax:

Administering Provider/Facility Information

Name:
Specialty:
NPI:
Phone:
Fax:

Step 2: Provider of Service and Treatment Information

Required for ALL requests

Treatment Start Date:
Diagnosis Code(s):
HCPCS:
Place of Service (Please Circle): Home Outpatient Provider Office

Step 3: Medical Information

Drug information

Drug Name: Dose: Frequency:
Length of Treatment: Diagnosis:

Step 4: Other Relevant History and Information	Please fax all required clinical documentation
Step 5: Contact Information	Please provide the name and telephone number (and extension, if applicable) of the person Wellmark Advantage Health Plan should notify when a decision is made. Name: _____ Phone: _____

Confidentiality notice: This transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify Wellmark Advantage Health Plan at 1-855-673-4225 immediately to arrange for the return of this document.

PLEASE FAX THE COMPLETED MEDICARE ADVANTAGE PART B BENEFIT DRUG FORM AND SUPPORTING DOCUMENTATION TO 1-877-218-0941

TO REQUEST AUTHORIZATION FOR DRUGS COVERED UNDER THE MEDICARE PART D PHARMACY BENEFIT, PLEASE CALL 1-855-344-0930