



(formerly WellFirst Health)

Request for Prior Authorization- Medical Injectables

Medica (formerly Wellfirst Health) 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 Fax : 608-252-0814



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