Coverage Determination Request Form – Florida Medicaid

Instructions: This form is used to determine coverage for prior authorizations, non-formulary medications (see formulary listings at www.wellcare.com), and medications with utilization management rules. Staywell will evaluate the request based on applicable medical criteria, FDA guidelines, protocols developed by the WellCare Pharmacy & Therapeutics Committee, and plan benefits.

Who is making this request? Provider ☐ Member ☐
Appointed Representatives: Please include a signed Appointment of Representative form (CMS-1696) or equivalent notice.

Complete each section legibly and completely (include any additional necessary medical records)

Member Name		Date of Request
WellCare ID #		Provider Name
Date of Birth		Provider Signature
Member's Telephone Number		Specialty
Member's Diagnosis		Sent By
Medication Requested **(list only one medication and strength per form)**		Provider Phone #
		Provider Fax #
Brand Medically Necessary? ☐ Yes ☐ No		Pharmacy Phone #
Medication Dose	Quantity	Pharmacy Fax #
Directions for Use		
Duration of Therapy		
Document clinical rationale for override/exception request. List all names and doses of previous medication(s) tried and failed. Fax all supporting documentation.		

FAX to Staywell Pharmacy Department at 1-866-825-2884
Information on this form is protected health information and is subject to all privacy and security regulations under HIPAA.