WellCare®
Beyond Healthcare. A Better You.

Medicare Drug Coverage Request Form

Instructions: Use this form to ask us to cover a drug that we would not usually cover or would restrict in some way. Please fill out **ALL REQUIRED FIELDS** of this form. Then fax it to WellCare's Pharmacy Department at **1-866-388-1767**. To see a list of the drugs we cover and rules we have about coverage, please visit **www.wellcare.com/medicare**.

If you need help filling out this form, ask your doctor or call us at the number on the back of your member ID card.

Important Note: Expedited Decisions

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 24 HOURS**
If you have a supporting statement from your doctor, please attach it to this request.

If you or your prescriber believes that waiting **72 hours for a standard decision** could seriously harm your life, health or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting **72 hours** could seriously harm your health, we will automatically give you a decision within **24 hours**. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. **You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received.**

You can also ask for a faster (expedited) initial review by calling 1-888-550-5252 *(TTY 711)*

Who is making this request? Provider ☐ Member ☐ Appointed Representative ☐

***Appointed Representatives*:** Please include a signed Appointment of Representative form (CMS-1696) or equivalent notice.

Complete the following section ONLY if the person making this request is not the member or prescriber:

Requestor's Name		
Requestor's Relationship to Member		
Address		
City	State	Zip Code
Requestor Phone		

Representation documentation for requests made by someone other than member or the member's prescriber: Attach documentation showing the authority to represent the member (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan or 1-800-Medicare.

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***REQUIRED FIELDS – ONE MEDICATION PER FORM.**

*Member Name:	
*Member ID #:	*Date of Birth:
Member Phone:	*Duration (how long therapy lasts): **Indefinite?** ☐ **YES** ☐ **NO** *If the box above is left blank, it will be assumed that the request is indefinite.*
*Drug Name/Strength/Form (e.g., tablet, capsule):	*Quantity: *Frequency (i.e., how often, how many):
***Generic Substitution Permitted:** ☐ **YES** ☐ **NO** *If this field is left blank, it is assumed that the request is for what the pharmacy is processing (if applicable). If there is no pharmacy claims history, it is assumed that the request is the specific form of the drug listed in the *Drug Name field.*	
*Associated Diagnosis: *list all diagnoses and ICD-10 codes being treated with the drug.*	
*Submitting Provider NPI:	*Provider Name (First Name & Last Name):
*Provider Mailing Address (including city, state, ZIP):	
Provider Phone:	Provider Fax:
*Office Contact Name:	*Provider Signature:
Pharmacy Name:	Pharmacy Phone:
*Drug Allergies:	
DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)	
Drugs Tried: if quantity limit is an issue, list unit dose/total daily dose tried	**RESULTS of previous drug trials. Indicate FAILURE vs. INTOLERANCE** (explain)
What is the member's current drug regimen for the condition(s) requiring the requested drug?	
If **TRANSPLANT DRUG:** Was the transplant covered by Medicare? ☐ **YES** ☐ **NO** When was the transplant? What date did you become Part A eligible? **Transplant Date:** **Part A Eligible Date:**	If **HOSPICE PATIENT:** Is medication related to the terminal condition? ☐ **YES** ☐ **NO**
HIGH-RISK MANAGEMENT OF DRUGS IN THE ELDERLY	
If the member is 65 and older, do you feel that the benefits of treatment with the requested drug outweigh the potential risks in this elderly patient? ☐ **YES** ☐ **NO**	

Type of Coverage Request (Please check boxes that describe restrictions for the drug you are asking for. If we ask for more information, you may include it below or on a separate page.):

❑ **Prior Authorization/Step Therapy – I need a drug with a requirement.** Please let us know how you have satisfied the requirements.

❑ **Non-Formulary Exception – I need a drug that is not on the plan's list of covered drugs.** Tell us all drugs you have tried that are on our list of covered drugs (sometimes called a "formulary"), but have not been effective for your treatment.

❑ **Quantity Limit Formulary Exception – I need a drug with a dosage and/or duration limit.** If we limit the number of doses and/or the duration, tell us why you need more of the restricted drug.

❑ **Prior Authorization/Step Therapy Exception – I need a drug with a requirement but am requesting an exception to the requirement.** Tell us why the requirement would not work or would have adverse effects.

❑ **Tiering Exception – I need a drug to be covered at a lower cost** – Tell us the drug(s) you have tried that is in a lower Tier and why those drug(s) would not be as effective as the drug you are asking for. **Please note: You cannot ask for a Tiering exception for a drug on Tier 1, Specialty Tier or for drugs not on our list of covered drugs.**

Reasons for Your Request. Use the space below and attach additional pages, if needed. **A supporting statement from your doctor is required.** Attach any information that supports your request, such as a statement from your doctor and relevant medical records.

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WellCare Health Plans, Inc., is an HMO, PPO, PDP, PFFS plan with a Medicare contract and is an approved Part D Sponsor. Enrollment in our plans depends on contract renewal.

WellCare Health Plans, Inc., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-877-374-4056 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-374-4056 (TTY: 711).

注愠：如果您使用繁體中文，您堯以兦費砲得語言栴助朠務。請致電1-877-374-4056 TTY：711）。