



### Coverage Determination Request Form – New Jersey Medicaid

Instructions: Fill out and return this form to request coverage for prior authorizations, non-formulary medications (see formulary listings at [www.wellcare.com](http://www.wellcare.com)), and medications with utilization management rules. WellCare of New Jersey 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 ( <b>list only one medication and strength per form</b> )		Provider Phone #
		Provider Fax #
Brand Medically Necessary? <input type="checkbox"/> Yes <input type="checkbox"/> 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 WellCare of New Jersey Pharmacy Department 1-888-340-9512**

Information on this form is protected health information and is subject to all privacy and security regulations under HIPAA.