

Medicaid Drug Coverage Request Form

Instructions: Please use this form to request coverage of 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 of Georgia's Pharmacy Department at **1-866-455-6558**. To see a list of the drugs we cover and rules we have about coverage, please visit us at www.wellcare.com/Georgia.

If you need help filling out this form, you may ask your doctor or call us at **1-866-231-1821 (TTY 711)**. We're here for you Monday through Friday, 7 a.m. to 7 p.m.

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.

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

*Member Name:	
*Member ID #:	*Date of Birth:
*Member Phone:	*Duration (how long therapy lasts): Indefinite? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If the box above is left blank, it will be assumed that the request is indefinite.</i>
*Drug Name/Strength/Form (i.e., tablet, capsule):	*Quantity:
	*Frequency (i.e., how often, how many):
*Generic Substitution Permitted: <input type="checkbox"/> YES <input type="checkbox"/> NO <i>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.</i>	
*Associated Diagnosis: <i>list all diagnoses and ICD-10 codes being treated with the drug.</i>	
*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?	

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 about all the 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.

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.

WellCare proudly serves the Georgia Medicaid and *PeachCare for Kids*® members enrolled in the *Georgia Families*® program and women enrolled in the *Planning for Healthy Babies*® program.



WellCare complies with all applicable federal civil rights laws. We do not exclude or treat people in a different way based on race, color, national origin, age, disability or sex.

If English is not your first language, we can translate for you. We can also give you info in other formats. That includes Braille, audio and large print. Just give us a call toll-free. You can reach us at **1-866-231-1821**. For TTY, call **711**.

Si el español es su lengua materna, podemos brindarle servicios de traducción. También podemos proporcionarle información en otros formatos, como braille, audio y letra de imprenta grande. Simplemente, llámenos sin cargo al **1-866-231-1821**. Para TTY llame al **711**.

Nếu Tiếng Việt là ngôn ngữ chính của quý vị, chúng tôi có thể thông dịch cho quý vị. Chúng tôi cũng có thể cung cấp cho quý vị thông tin ở các định dạng khác như chữ nổi Braille, âm thanh và bản in cỡ lớn. Chỉ cần gọi chúng tôi theo số miễn phí **1-866-231-1821** (TTY **711**).