‘Ohana Health Plan – Coverage Determination Request Form

Instructions: This form is used to determine coverage for prior authorizations and medications with utilization management rules. ‘Ohana will evaluate the request based on applicable medical criteria, FDA guidelines, protocols developed by the ‘Ohana Pharmacy and Therapeutics Committee and plan benefits. Please complete ALL FIELDS and fax this form to WellCare’s Pharmacy Department at **1-888-877-8239**. The Preferred Drug List and utilization management criteria may be reviewed at www.ohanahealthplan.com.

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

Please Check One (Not checking a box will indicate a Standard Review.)
☐ **REQUEST FOR STANDARD REVIEW (14 DAYS)**
☐ **REQUEST FOR EXPEDITED REVIEW (72 HOURS)**
By checking the Expedited Review box, the requestor certifies that applying the Standard Review time frame may seriously jeopardize the life or health of the member or the member’s ability to regain maximum function.

***REQUIRED FIELDS – ONE medication per form**

*Member Name:		*Date of Request**:**	
*’Ohana ID#:	*Date of Birth:	*Physician FULL Name/Specialty**:**	
*Member’s Telephone Number:		*Physician Signature**:**	
*Diagnosis of Requested Medication**:**		*Contact Name at MD Office**:**	*Physician NPI**:**
*****Medication, Strength and Route of Administration:		*Physician Phone**:**	
		*Physician Fax**:**	
		Pharmacy Name**:**	
*Frequency**:**	*Quantity:	Pharmacy Phone:	
*Duration of Therapy**:**	*Drug Allergies:	Pharmacy Fax:	
Document clinical rationale for request. List all names and doses of previous medication(s) tried and failed. Include all supporting documentation.			