



Coverage Determination Request Form – Harmony Health Plan

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. Harmony Health Plan 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Pharmacy Phone #
Medication Dose	Quantity	Pharmacy Fax #
Directions for Use		
Duration of Therapy		
<u>Supporting Documentation:</u>		
<ul style="list-style-type: none"> • 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 Harmony Health Plan Pharmacy Department 1-888-481-9753

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

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