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 at **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
You can ask for a faster (expedited) initial review by calling ***1-888-550-5252****.*

If you or your prescriber believe 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.

☐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.

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

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

*Member's Name:	
*WellCare ID #:	*Date of Birth:
*Member Telephone Number:	*Date of Request:
*Provider Name and Specialty:	*Provider's NPI:
*Provider Address (including city, state, ZIP):	
*Provider Phone:	*Provider Fax:
*Office Contact Name:	*Provider Signature:

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Pharmacy Name:	Pharmacy Phone:
Medication Requested:	Condition the Medication Treats:
Strength and Type (for example, pill or shot):	How Long Therapy Lasts:
How Many Doses and Often Taken (For example, “one pill, twice daily.”) Check label if unsure:	
If TRANSPLANT DRUG: Was the transplant covered by Medicare? When was the transplant? ☐ Yes ☐ No Transplant Date:	If HOSPICE PATIENT: Is medication related to the terminal condition? ☐ 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** – Please let us know why you are asking us to approve coverage of this drug.

❑ **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*** – If we limit the number of doses, tell us the reason why you need more of the restricted drug.

❑ **Prior Authorization/Step Therapy Exception*** – I request an exception to the requirement. Tell us why the requirement would not work or would have adverse effects.

❑ **Tiering Exception*** (asking for 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. Attach any information that supports your request, such as a statement from your doctor and relevant medical records. ***A supporting statement from your doctor is required.**

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

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-374-4056** (TTY: **711**)。

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