Rev. 12/07

Medicare Coverage Determination Request Form

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. WellCare will evaluate the request based on medical criteria, FDA guidelines and protocols developed by the WellCare Pharmacy & Therapeutics Committee.

Who is making this request? Physician ☐ Member ☐ Pharmacy ☐ Appointed Representative ☐

The following review criteria are used in reviewing drug evaluations and requests for overrides:

- Patient has tried and failed an appropriate trial of generic or preferred medications.
- Other therapeutically equivalent medications are contraindicated in the patient.
- Choices available are not suited for the present patients care and the medication requested is required for patient safety.
- An alternative choice may provoke an underlying medical condition, which would be detrimental to the care of the patient.

Complete each section legibly and completely (include any additional necessary medical records)

Member Name		Date of Request
WellCare ID #	State:	Physician Name
Date of Birth	**Pt currently in LTC?** Yes or No	Physician Signature
Member's Telephone Number		Specialty
Diagnosis of Requested Medication		Sent by
Medication Requested		Physician Phone #
Dose	Dosage Form	Physician Fax #
Directions for Use	Quantity	Pharmacy Phone #
Duration of Therapy		Pharmacy Fax #
Clinical reason for override (previous medications tried and failed and any other pertinent Details). Please fax additional supporting pages as necessary.		

( ) **REQUEST FOR EXPEDITED REVIEW (24 HOURS)**

BY CHECKING THIS BOX, THE PRESCRIBING PHYSICIAN INDICATED ABOVE OR PHYSICIAN'S AGENT CERTIFIES THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION.

FAX to: WellCare Pharmacy 1-866-388-1767 **For Internal Use Only**