



Coverage Determination Request Form - Ohio

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 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 #		Physician Name
Date of Birth:		Physician Signature
Member's Telephone Number		Specialty
Diagnosis of Requested Medication		Sent By
Medication Requested (list only one medication and strength per form)		Physician Phone #
		Physician Fax #
Medication Dose	Dosage Form	Pharmacy Phone #
Directions for Use	Quantity	Pharmacy Fax #
Duration of Therapy		
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 WellCare Pharmacy Department 1-877-277-6892

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