Wellcare Buckeye Health Dual Access (HMO D-SNP)
Wellcare Buckeye Health Dual Reserve (HMO D-SNP

REQUEST FOR MEDICARE DRUG COVERAGE DETERMINATION

Use this form to ask our plan for a coverage determination. You can also ask for a coverage determination by phone at 1-833-998-4953, TTY: 711. From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays. Or through our website at go.wellcare.com/BuckeyeOH. You, your doctor or prescriber, or your authorized representative can make this request.

Plan Enrollee

Name	Date of birth
Street address	City
State	ZIP
Phone	Member ID #

If the person making this request isn't the plan enrollee or prescriber:

Requestor's name
Relationship to plan enrollee
Street address (include City, State and ZIP)
Phone
☐ Submit documentation with this form showing your authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or equivalent). For more information on appointing a representative, contact our plan or call 1-800-MEDICARE. (1-800-633-4227). TTY users can call 1-877-486-2048.

Name of drug this request is about (include dosage and quantity information if available)

Type of Request

☐ My drug plan charged me a higher copayment for a drug than it should have

☐ I want to be reimbursed for a covered drug I already paid for out of pocket

☐ I'm asking for prior authorization for a prescribed drug (this request may require supporting information)

For the types of requests listed below, your prescriber MUST provide a statement supporting the request. Your prescriber can complete pages 3 and 4 of this form, "Supporting Information for an Exception Request or Prior Authorization."

☐I need a drug that's not on the plan's list of covered drugs (formulary exception)

☐ I've been using a drug that was on the plan's list of covered drugs before, but has been or will be removed during the plan year (formulary exception)

☐ I'm asking for an exception to the requirement that I try another drug before I get a prescribed drug (formulary exception)

☐ I'm asking for an exception to the plan's limit on the number of pills (quantity limit) I can get so that I can get the number of pills prescribed to me (formulary exception)

☐ I'm asking for an exception to the plan's prior authorization rules that must be met before I get a prescribed drug (formulary exception).

☐ My drug plan charges a higher copayment for a prescribed drug than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception)

☐ I've been using a drug that was on a lower copayment tier before, but has or will be moved to a higher copayment tier (tiering exception)

Additional information we should consider *(submit any supporting documents with this form)*:

_____

_____

_____

_____

Do you need an expedited decision?

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'll automatically give you a decision within 24 hours. If you don't get your prescriber's support for an expedited request, we'll decide if your case requires a fast decision. (You can't ask for an expedited decision if you're asking us to pay you back for a drug you already received.)

☐ **YES, I need a decision within 24 hours.** If you have a supporting statement from your prescriber, attach it to this request.

Signature:	**Date:**

How to submit this form

Submit this form and any supporting information by mail or fax:

Address:
Medicare Pharmacy Prior Authorization Department
P.O. Box 31397
Tampa, FL 33631-3397

Fax Number:
1-866-226-1093

Supporting Information for an Exception Request or Prior Authorization
To be completed by the prescriber

☐ **REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72-hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.**

Prescriber Information

Name
Street Address (Include City, State and ZIP)
Office phone
Fax
Signature Date

Diagnosis and Medical Information

Medication:	Strength and route of administration:
Frequency:	Date started: ☐ **NEW START**
Expected length of therapy:	Quantity per 30 days:
Height/Weight:	Drug allergies:

DIAGNOSIS – Please list all diagnoses being treated with the requested drug and corresponding ICD-10 codes **(**If the condition being treated with the requested drug is a symptom e.g. anorexia, weight loss, shortness of breath, chest pain, nausea, etc., provide the diagnosis causing the symptom(s) if known)	**ICD-10 Code(s)**
Other RELEVANT DIAGNOSES:	**ICD-10 Code(s)**

DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)

DRUGS TRIED (if quantity limit is an issue, list unit dose/total daily dose tried)	**DATES of Drug Trials**	**RESULTS of previous drug trials FAILURE vs INTOLERANCE (explain)**

What is the enrollee's current drug regimen for the condition(s) requiring the requested drug?

DRUG SAFETY	
Any **FDA NOTED CONTRAINDICATIONS** to the requested drug?	☐ **YES** ☐ **NO**
Any concern for a **DRUG INTERACTION** when adding the requested drug to the enrollee's current drug regimen?	☐ **YES** ☐ **NO**
If the answer to either of the questions above is yes, please 1) explain issue, 2) discuss the benefits vs potential risks despite the noted concern, and 3) monitoring plan to ensure safety	
HIGH RISK MANAGEMENT OF DRUGS IN THE ELDERLY	
If the enrollee is over the age of 65, do you feel that the benefits of treatment with the requested drug outweigh the potential risks in this elderly patient?	☐ **YES** ☐ **NO**
OPIOIDS – (answer these 4 questions if the requested drug is an opioid)	
What is the daily cumulative Morphine Equivalent Dose **(MED)**?	_____ **mg/day**
Are you aware of other opioid prescribers for this enrollee? If so, please explain.	☐ **YES** ☐ **NO**
Is the stated daily MED dose noted medically necessary?	☐ **YES** ☐ **NO**
Would a lower total daily MED dose be insufficient to control the enrollee's pain?	☐ **YES** ☐ **NO**

RATIONALE FOR REQUEST

☐ **Alternate drug(s) previously tried, but with adverse outcome, e.g. toxicity, allergy, or therapeutic failure.** If not noted in the DRUG HISTORY section, specify below: (1) Drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure, list maximum dose and length of therapy for drug(s) trialed.

☐ **Alternative drug(s) contraindicated, would not be as effective or likely to cause adverse outcome.** A specific explanation why alternative drug(s) would not be as effective or anticipated significant adverse clinical outcome and why this outcome would be expected is required. If contraindication(s), list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated

☐ **Patient would suffer adverse effects if he or she were required to satisfy the prior authorization requirement.** A specific explanation of any anticipated significant adverse clinical outcome and why this outcome would be expected is required.

☐ **Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change** A specific explanation of any anticipated significant adverse clinical outcome and why this outcome would be expected is required – e.g. the condition has been difficult to control (many drugs tried, multiple drugs required to control condition), the patient had a significant adverse outcome when the condition was not controlled previously (e.g. hospitalization or frequent acute medical visits, heart attack, stroke, falls, significant limitation of functional status, undue pain and suffering),etc.

☐ **Medical need for different dosage form and/or higher dosage** Specify below: (1) Dosage form(s) and/or dosage(s) tried and outcome of drug trial(s); (2) explain medical reason (3) include why less frequent dosing with a higher strength is not an option – if a higher strength exists.

☐ **Request for formulary tier exception** If not noted in the DRUG HISTORY section, specify below: (1) formulary or preferred drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure/not as effective as requested drug, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated.

☐ **Other** (explain below)

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_____

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