



## Coverage Determination Request Form- Georgia

Instructions: This form is used to determine coverage for prior authorizations, non-formulary medications (see formulary listings at [www.wellcare.com](http://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 ( <b>list only one medication and strength per form</b> )		Physician Phone #
Dose	Dosage Form	Physician Fax #
Directions for Use	Quantity	Pharmacy Phone #
Duration of Therapy		Pharmacy Fax #
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 1-866-455-6558**

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