Wellcare Prime by Absolute Total Care
(Medicare-Medicaid Plan)

Healthy Connections PRIME

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 1-855-735-4398 (TTY: 711). Or through our website at mmp.absolutetotalcare.com. Member Service hours are from 8 a.m. to 8 p.m. ET, Monday through Friday. After hours, on weekends and on federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. You, your doctor or prescriber, or your authorized representative can make this request.

Plan Member

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

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

Requestor's name
Relationship to plan member
Street address (include City, State and ZIP)
Phone
☐ Submit documentation with this form showing your authority to represent the member (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:
1-877-941-0480

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 member or the member'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 member'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 member'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 member 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 member? 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 member'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)

_____

_____

_____

_____

Wellcare Prime by Absolute Total Care (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and South Carolina Healthy Connections Medicaid to provide benefits of both programs to enrollees.

ATENCIÓN: Si habla español, contamos con servicios de asistencia lingüística que se encuentran disponibles para usted de manera gratuita. También contamos con servicios y asistencia auxiliares adecuados para proporcionar información en formatos accesibles de manera gratuita. Llame al 1-855-735-4398 (TTY: 711) o hable con su proveedor.

注意：如果您说中文（普通话），我们将为您提供免费的语言协助服务。我们还免费提供相应的辅助工具和服务，以无障碍方式提供信息。请致电 1-855-735-4398 (TTY: 711) 或咨询您的医疗服务提供者。

注意：如果您講廣東話，您可以免費使用語言協助服務。也免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請致電 1-855-735-4398 (TTY：711) 或洽詢您的服務提供者。

ATENSYON: Kung nagsasalita kayo ng Tagalog, may mga libreng serbisyo ng tulong sa wika na available para sa inyo. Available din nang libre ang mga naaangkop na karagdagang tulong at serbisyo para makapagbigay ng impormasyon sa mga accessible na format. Tumawag sa 1-855-735-4398 (TTY: 711) o makipag-usap sa inyong tagapagbigay ng serbisyo.

REMARQUE : si vous parlez français, un service d'assistance linguistique gratuit est à votre disposition. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-735-4398 (TTY : 711) ou contactez votre fournisseur.

LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Hỗ trợ và dịch vụ phụ trợ phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận cũng được cung cấp miễn phí. Gọi 1-855-735-4398 (TTY: 711) hoặc trao đổi với nhà cung cấp của quý vị.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachdienstleistungen zur Verfügung. Entsprechende weitere Unterstützung und Dienste zur Bereitstellung von Informationen in zugänglichen Formaten stehen Ihnen ebenfalls kostenlos zur Verfügung. Rufen Sie folgende Nummer an oder wenden Sie sich an Ihren Anbieter: 1-855-735-4398 (TTY: 711).

주의: 한국어를 구사할 경우, 언어 보조 서비스를 무료로 이용 가능합니다. 제공 정보의 적합한 보조 지원과 서비스 또한 접근 가능한 형식으로 무료로 제공됩니다. 1-855-735-4398(TTY: 711) 번으로 전화하거나 제공자에게 문의하십시오.

ВНИМАНИЕ: если вы говорите по-русски, вам доступны бесплатные услуги помощи на родном языке. Вам также бесплатно доступны соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах. Позвоните по номеру 1-855-735-4398 (TTY: 711) или обратитесь к своему поставщику услуг.

تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية المجانية متوفرة لك. تتوفر أيضًا أدوات المساعدة والخدمات الإضافية المناسبة لتقديم المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل بالرقم 1-855-735-4398 (TTY: 711) أو تحدث إلى مزود الخدمة الخاص بك.

ATTENZIONE: se parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili, a titolo gratuito, adeguati servizi e supporti ausiliari per fornire le informazioni in formati accessibili. Contatti il numero 1-855-735-4398 (TTY: 711) oppure si rivolga al Suo fornitore.

ATENÇÃO: se falar português, estão disponíveis serviços de assistência gratuitos no seu idioma. Também estão disponíveis de forma gratuita materiais e serviços de apoio adequados para fornecer informações em formatos acessíveis. Ligue para 1-855-735-4398 (TTY: 711) ou fale com o seu prestador de cuidados.

ATANSYON: Si ou pale Kreyòl Ayisyen, gen sèvis asistans gratis ki disponib. Epitou w ap jwenn aparèy ki bay sipò ak sèvis ki bay enfòmasyon nan fòma ki aksesib gratis. Rele nan 1-855-735-4398 (TTY: 711) oswa pale ak founisè w lan.

UWAGA: jeśli mówisz w języku polskim, możesz skorzystać z bezpłatnych usług językowych. Dostępne są również bezpłatne dodatkowe materiały pomocnicze i usługi mające na celu dostarczenie informacji w dogodnym formacie. Zadzwoń pod numer 1-855-735-4398 (TTY: 711) lub porozmawiaj ze swoim dostawcą usług.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। सुलभ प्रारूप में जानकारी प्रदान करने के लिए उपयुक्त सहायक उपकरण और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-735-4398 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

УВАГА! Якщо ви володієте українською мовою, вам доступні безкоштовні послуги мовної підтримки. Відповідні допоміжні засоби та послуги для надання інформації в доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-855-735-4398 (TTY: 711) або зверніться до свого постачальника.

پاملرنه: که تاسو په پښتو خبرې کوئ، تاسو لپاره د وړیا ژبې مرستې خدمتونه موجود دي. د لاسرسي وړ فورمو کې د معلوماتو چمتو کولو لپاره مناسب مرستندویه مرستې او خدمات هم وړیا شتون لري. 1-855-735-4398 (TTY: 711) ته زنګ ووهئ یا خپل چمتو کونکي سره خبرې وکړئ.

লক্ষ্য করুন: আপনি বাংলাতে কথা বললে আপনার জন্য বিনামূল্যে ভাষা সহায়তার পরিষেবা উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফর্ম্যাটে তথ্য সরবরাহ করতে যথাযথ অতিরিক্ত সহায়ক ও পরিষেবাগুলিও বিনামূল্যে পাওয়া যায়। 1-855-735-4398 (TTY: 711) নম্বরে কল করুন বা আপনার প্রোভাইডারের সাথে কথা বলুন।

توجه: اگر فارسی صحبت می‌کنید، خدمات کمک‌زبانی رایگان به شما ارائه می‌دهیم. کمک‌ها و خدمات تکمیلی مناسب برای ارائه اطلاعات در قالب‌های دسترس‌پذیر نیز به طور رایگان دراختیارتان قرار می‌گیرد. با شماره 1-855-735-4398 (TTY: 711) تماس بگیرید یا با ارائه‌دهنده‌تان صحبت کنید.

VËMENDJE: Nëse flisni shqip, janë të disponueshme shërbime ndihmëse gjuhësore pa pagesë. Ofrohen gjithashtu pajisje dhe shërbime ndihmëse të përshtatshme për të dhënë informacion në formate të aksesueshme pa pagesë. Telefononi në numrin 1-855-735-4398 (TTY: 711) ose flisni me ofruesin tuaj.

توجه: اگر شما به زبان دری صحبت می کنید، خدمات کمک زبان رایگان برای شما موجود است. کمک ها و خدمات کمکی مناسب برای ارائه معلومات در فارمت های قابل دسترس نیز به صورت رایگان در دسترس هستند. با شماره 1-855-735-4398 (TTY: 711) تماس بگیرید یا با ارائه دهنده خود صحبت کنید.

注意：日本語を話される方は、無料で言語支援サービスを利用できます。アクセス可能なフォーマットで適切なサポートや補助サービスを無料で受けることもできます。1-855-735-4398 （TTY: 711）までお電話いただくか、プロバイダーにご相談ください。