



Medicare Drug Evaluation Review Form

Instructions: This form is used to obtain coverage for non-formulary medications (see formulary listings at www.wellcarepdp.com) WellCare will evaluate the request based on medical criteria and protocols developed by the WellCare Pharmacy & Therapeutics Committee **Please note that members enrolled in Wellcare's plan will not have to pay a copay for generic medications**, which decreases the patient's chances of hitting the Medicare Part D coverage gap.

The Following Review Criteria Are Used In Reviewing Drug Evaluations And Request for Overrides:

- Patient has 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 patient care and the drug selected is required for patient safety
- An alternative choice may provoke an underlying medical condition, which would be detrimental to patient care.

Complete Each Section Legibly and Completely (include fax of necessary medical records)

Member Name		Date of Request
Health Plan ID#		Health Plan: Wellcare PDP State: _____ Plan: <input type="checkbox"/> Signature <input type="checkbox"/> Complete <input type="checkbox"/> Premier
DOB		Physician Name
Diagnosis		Specialty
Drug Name		Sent By
Dose	Dosage Form	Physician's Phone
Strength	Qty	Physician's Fax
Length of Treatment		Pharmacy Phone
Clinical Reason for Override (including medical documentation)		Previous medications that failed (include drug, dose, strength)
History (If require additional space, please send a separate sheet with the additional information including the patient's ID #, DOB, and name. Also, please send all pertinent medical records)		

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