



Medicare Part D Coverage Determination Request Form for Diazepam

Instructions: Please complete ALL FIELDS and fax this form to WellCare's Pharmacy Department at **1-877-277-1809**.

Formulary and utilization management criteria may be reviewed at www.easychoicehealthplan.com.

Who is making this request? Provider

Appointed Representatives: Please include a signed Appointment of Representative form (CMS-1696) or equivalent notice.

REQUEST FOR EXPEDITED REVIEW (24 HOURS)

By checking the expedited box, the requestor certifies that applying the 72-hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

***REQUIRED FIELDS – ONE medication per form**

*Member Name:		*Date of Request:	
*<WellCare/Ohana/Easy Choice> ID #:	*Date of Birth:	*Physician FULL Name/Specialty:	
*Member's Telephone Number:		*Physician Signature:	
*Diagnosis of Requested Medication:		*Contact Name at MD Office:	*Physician NPI:
*Medication, Strength, and Route of Administration:		*Physician Phone #:	*Physician Fax #:
		Pharmacy Name:	Pharmacy Phone #:
*Frequency:	*Quantity:	*Duration of Therapy:	*Drug Allergies:

PLEASE COMPLETE THIS SECTION IF THE PATIENT IS 65 YEARS OF AGE AND OLDER:

For the management of anxiety disorders or for the short-term relief of the symptoms of anxiety:

1. Is the requested drug being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety? YES NO

2. Has the patient experienced an inadequate treatment response, intolerance, or contraindication to a selective serotonin reuptake inhibitor (SSRI) (e.g., escitalopram, sertraline) or a serotonin-norepinephrine reuptake inhibitor (SNRI) (e.g., duloxetine, venlafaxine ER)? YES NO

3. Is the duration of therapy 4 months or less? YES NO
 If no, please provide clinical rationale: _____

For the symptomatic relief in acute alcohol withdrawal or as an adjunct for the relief of musculoskeletal spasms:

1. Does the benefit of therapy with this prescribed medication outweigh the potential risk in the patient 65 or older? YES NO

2. Is the request for more than four times a day dosing? YES NO

If yes, we require a statement that the drug is medically necessary to treat the enrollee's condition because the restricted dosage might be ineffective or affect patient compliance.

Supporting statement:
