Wellmark®

Pharmacy Internal Appeal and External Review Request Form

Use this form to request an internal appeal or an external review of a denial related to pharmacy prior authorization, brand penalty waiver or formulary exception. Before submitting your request, please review the appeal rights included with your adverse benefit determination or denial notice. Visit **wellmark.com/member/forms** to confirm you are requesting the right type of review and sending your request to the correct location.

PLEASE PRINT OR TYPE INFORMATION

Member Information

Patient Name_____ Member Wellmark ID_____

Patient Date of Birth _____/_____/_____ Phone Number_____

Mailing Address_____

Prescribing Provider Information

Provider Name_____ Specialty_____

Mailing Address_____

NPI_____ Phone Number (_____)_____ Fax Number (_____)_____

Prescription Information

Medication Name_____ Strength_____

Quantity_____ Expected Length of Therapy_____

ICD_____ Medical Condition Being Treated_____

Type of Appeal or Review

Initial Internal Appeal*:** Complete this section when this is your first appeal. Tell us what type of decision you are appealing. Must be submitted ***within 180 days from the date the notice of an initial adverse benefit determination or denial was issued.
Check the applicable box below

- ☐ Internal Appeal of a denial of a non-formulary drug exception request (you have received an initial denial)
- ☐ Internal Appeal of a denial of a pharmacy prior authorization request (you have received an initial denial)
- ☐ Internal Appeal of a denial of a brand penalty waiver request (you have received an initial denial)

External Review*:** Complete this section when you have already appealed, and received a denial. Must be submitted ***within 120 days from the date the notice of a final internal adverse benefit determination or denial was issued.
Check the applicable box below

- ☐ External Review of an appeal decision resulting in a denial of a non-formulary drug exception request (you have received an initial denial AND an internal appeal response)
- ☐ External Review of an appeal decision resulting in a denial of a pharmacy prior authorization request (you have received an initial denial AND an internal appeal response)
- ☐ External Review of an appeal decision resulting in a denial of a brand penalty waiver request (you have received an initial denial AND an internal appeal denial)

Is this an urgent expedited request?

- ☐ Check this box if you have *supporting documentation or statement from your prescriber* that a standard review timeframe may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Note: This form may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient, you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received this fax in error, please immediately notify the sender by telephone and destroy this original fax message.

Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc., Wellmark Advantage Health Plan, Inc., and Wellmark Blue Cross and Blue Shield of South Dakota are independent licensees of the Blue Cross and Blue Shield Association.

This request will be reviewed using the information provided at the time of review. Missing clinical information may impact our ability to complete a full evaluation.

For all initial Internal Appeal or External Review requests, please include (if available):

- A copy of the denied request
- Any supporting medical records, such as clinical notes, test results, or other documentation
- A list of medications you have tried for this condition, including how long you used each one and how well it worked
- A letter from your provider explaining why:
  - The denial may not be correct
  - The requested medication is medically necessary, AND
  - Other available medications have not been effective or have caused side effects or would not be as effective as the requested medication

Submitter Information (Required) Tell us who is submitting this form.

☐ Member - Please provide ***signature*** in area below

☐ Provider/Prescribing Clinician - **STOP** - Complete Provider Attestation section below

☐ Other (specify) - **MUST** fill out section below, sign, and include the Personal Representative Appointment and Authorization to Release Protected Health Information form located at **wellmark.com/member/forms**

Other Name_____

Title/Relationship to Member_____

Phone_____

Fax or Email_____

Signature_____ Date_____/_____/_____

Provider/Prescribing Clinician Attestation - complete **ONLY** if submitter is a provider

☐ I am the treating provider submitting this request on behalf of my patient, and I have authorization of the patient to participate in this appeal and provide supporting information on the patient's behalf.

☐ Documentation of the Patient's authorization to represent them in this appeal can be provided upon request.

Provider/Prescribing Clinician Signature_____ Date_____/_____/_____

Where to Send Your Request

Please send your completed request and supporting documents to the appropriate address or fax number below. **Be sure to review your appeal rights included with your denial notice or visit wellmark.com/member/forms** to confirm you are requesting the correct type of review and sending it to the correct location.

Retail Pharmacy Medications
Mail or fax your request to:
CVS Caremark Prescription Claim Appeals MC 109
PO Box 52084
Phoenix, AZ 85072
Fax: 1-866-443-1172

Specialty Pharmacy Medications
Mail or fax your request to:
CVS Caremark Specialty Appeals Department
800 Biermann Court
Mount Prospect, IL 60056
Fax: 1-855-230-5548

Wellmark Language Assistance

Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc. and Wellmark Blue Cross and Blue Shield of South Dakota are independent licensees of the Blue Cross and Blue Shield Association.

Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. Wellmark does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Wellmark

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 3E417, Des Moines, IA 50309-2901, 515-376-6500, TTY 888-781-4262, Fax 515-376-9055, Email **CRC@Wellmark.com**. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意： 如果您说普通话， 我们可免费为您提供语言协助服务。 请拨打 800-524-9242 或 （听障专线： 888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم ٢٤٢٩-٤٢٥-٠٠٨ أو (خدمة الهاتف النصي: ٨٨٨-١٨٧-٢٦٢٤).

ສ່ວນຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານ ໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ຫາ. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, निःशुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION: Si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တtill်ုးသွင်ည၊–နမ့်ကတီးကညီကျိ်ာ်.ကျိ်ာတ်မၤစၢၤတ်ဖံးတ်မၤတဖဉ်.လၢတဘဉ်လၢာ်ဘူးလဲ.ဆိဉ်လၢနဂ်ီလီၤ.ဆဲးကျိုးဆူ ၈၀၀–၅၂၄–၉၂၄မ့တမ့်(TTY:၈၈၈–၇၈၁–၄၂၆)တက့်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि निःशुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ । 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस् ।

ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ጄሙላው ያነጋግሩን።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heƃir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojį' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)