



Specialty Medication Early Refill Request Form

Thank you for being a member of Wellmark Blue Cross and Blue Shield. Please review the instructions below for helpful information on how to submit your request so it can be processed quickly and accurately. Note: All fields on this form are required in order to be processed correctly. Incomplete request forms will not be processed. Complete the form using a blue or black pen. Please do not use highlighters.

This form should be used when requesting an override beyond the standard prescription refill timeframe for specialty medications covered under the pharmacy benefit. Requests will not be approved for lost, stolen, or damaged medications.

Member Instructions:

1. Complete the form in its entirety, initial next to the acknowledgments, and sign once complete.
2. Submit a separate request form for each policy member. Retain copies of all documents for your records.
3. If you need additional room to add more prescriptions please use the back of the form.
4. Email your completed form and proof of travel to cspharmacyspecialist@wellmark.com.

Please submit your form 2 weeks prior to the anticipated pick up/delivery date for the requested medication. If approved, the order can be placed up to 5 days prior to the anticipated pick up/delivery date. Urgent requests are completed based on business capacity.

If you have questions or need assistance go to wellmark.com or call Customer Service at the phone number shown on the back of your Wellmark ID card.

Note: If you have already contacted Customer Service to initiate your request, this form will need to be submitted within 3 days from initial contact.

Member Information			
Policyholder Name		Wellmark ID Number	
Policyholder Phone Number			
Patient Name		Patient DOB	

Prescription Information		
Medication Name (brand and/or generic name) and strength	Dose	Month Supply Being Requested

Travel Information			
Reason for early fill		Travel Destination	
Date of departure		Date of return	

Acknowledgments (please initial each box)

_____ I certify that the proof of travel included with this request is accurate and true for the person listed above requesting an early refill, and such travel has not been canceled as of the date this Form is submitted.

- Proof of Travel can be in the form of a flight itinerary, hotel reservation, cruise ticket, letter from employer, etc.
- Financial information such as credit card number or financial institution information, travel numbers (e.g., frequent flier numbers or SSNs or confirmation codes) should be removed or blacked out prior to submitting.

Acknowledgments, cont'd.

_____ I understand that I can only be approved for 1 early refill per 12 months, and I attest that I have not received an early refill within the last 12 months.

_____ I understand that Wellmark will not cover lost, stolen, or damaged medications. Damaged medications include improper storage of medications that makes the medications unusable.

_____ I understand that my next refill date will not be until 75% of days/medication is used.

_____ I understand that vendor discounts such as coupons or copay cards may not apply to an early refill and that it is my responsibility to verify with the manufacturer or discount program administrator to verify.

_____ I understand that if approved it is my responsibility to store the medications according to the pharmacist/patient and manufacturer instructions.

_____ I understand that Wellmark is not responsible for missed or incorrect deliveries due to inaccurate information supplied by the member.

By signing this document, I certify that the information given is complete and correct, and that I am requesting an early refill only for the specific medications listed for the patient named above.

Signature of Member _____ Date ____/____/____
(or Policyholder if Member is under 18)

List additional medications here if needed:

Prescription Information (continued from front)		
Medication Name (brand and/or generic name) and strength	Dose	Month Supply Being Requested

Asistencia de idiomas de Wellmark

La discriminación es ilegal

Wellmark Blue Cross and Blue Shield cumple las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, país de origen, edad, discapacidad, sexo, orientación sexual o identidad de género.

Wellmark da:

- Ayuda y servicios gratis a personas con discapacidades para que puedan comunicarse de manera eficaz con nosotros, como:
 - Intérpretes calificados de lenguaje de señas
 - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- Servicios de idiomas gratis para personas cuyo idioma principal no es el inglés, como:
 - Intérpretes calificados
 - Información escrita en otros idiomas

Tiene derecho a obtener esta información y ayuda en su idioma gratis. Si usted necesita estos servicios, llame al 800-524-9242.

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 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ທັນທີ. (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, नि:शुल्क 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 Deutsch 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).

တစ်ခုခုပြော-နည်းကတိကဉ်ကျိန်, ကျိန်တစ်စတစ်စတစ်စတစ်စ, လာတတ်လားဘူးလဲ, ဆိုလို့လာနိဂီလိလိ, ဆဲးကျိန်ဆူ ၈၀၀-၅၂၄-၉၂၄ ညမှတ်မှတ် (TTY: ၈၈၈-၇၈၁-၄၆၆) တတ်မှတ်.

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 नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: ከማርኛ የሚናገሩ ከሆነ፣ የቋንቋ አገዛ አገልግሎቶቹ፣ ከከፍተኛ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ዲው-አው-ያንገግግ።

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

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

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' adoowól, t'áá jiik'é, náhóló. Kojí' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)