

## Part D QIC Drug Appeal Case File Transmittal Form

### 1. Appeal Information:

(Check one for each line.)

- a. Priority:  Expedited  Standard
- b. Appeal Type:  Prospective  Retrospective
- c. Applicable Coverage Year(s): \_\_\_\_\_
- d. Does this case involve a cost sharing issue?  Yes  No
- e. Is this case an auto forward?  Yes  No

### 2. Enrollee Data:

Enrollee Name: \_\_\_\_\_ Enrollee (HICN) or Enrollee (MBI): \_\_\_\_\_  
 Enrollee Street: \_\_\_\_\_ Enrollee Phone: \_\_\_\_\_  
 Enrollee City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Enrollee Date of Birth: \_\_\_\_\_

Is the Enrollee Deceased?  Yes  No

Does the Enrollee Require the final determination notice in a language other than English?

No  Yes  Language needed:

Does the Enrollee require communication be made in any alternate format?

No  Yes  Specify format:

Large print (if other than 18 point font, indicate size below)  Audio CD  Braille  Qualified Reader

Other (specify type of format or font) \_\_\_\_\_

### 3. Requestor Data:

- Enrollee is requestor  Enrollee's treating physician
- Enrollee's estate, Is estate documentation in file?  Yes  No
- Representative, Is an AOR or Power of Attorney in file?  Yes  No
- Surrogate acting in accordance with state law  Yes  No

### Plan Attestation for Representative Appeals:

I attest on behalf of the Part D Plan sponsor that the above referenced representative appealed at the Plan level and is a valid representative of the enrollee under State law.

Signed: \_\_\_\_\_ Print Name: \_\_\_\_\_

Requested appeal at Coverage Determination  Requested appeal at Redetermination

Name of Requestor: \_\_\_\_\_ Company Name: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_  
 Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### 4. Medicare Health Plan Data:

#### Plan Type:

PDP (S#)  MA PD (H or R#)  MMP (H# or R#)  Cost  Employer Sponsored (E#)

Plan Contract #: \_\_\_\_\_ Enter 4-digit CMS Plan #: \_\_\_\_\_ Plan ID #: \_\_\_\_\_ Formulary Name/Formulary ID #: \_\_\_\_\_

Plan Contact Representative Name and Title: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Contact Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Plan Level 0: Coverage Determination:**

**Coverage Determination (CD):**

Date Coverage Determination requested:

Did the Appellant ask the Plan to expedite? Yes  No

Did the Plan grant an expedited review? Yes  No

**For Determinations Involving an Exceptions Request:**

Did the Plan extend the minimum timeframes to obtain a prescriber statement? Yes  No

Date prescriber statement requested:

Date prescriber statement received:

Decision Date:

Was CD untimely? Yes  No

**Plan Level 1: Redetermination:**

**Redetermination Decision (RD):**

Date Redetermination requested:

Did the Appellant ask the plan to expedite? Yes  No

Did the Plan grant an expedited review? Yes  No

Decision Date:

Was the RD untimely? Yes  No

**Drug Benefit in Dispute:**

\*\*\* NOTE: If multiple drugs are in dispute, print and complete a separate version for each drug in dispute\*\*\*

Name of Drug:

Strength/Dosage/Amount/Refill Number (e.g. 20 mg BID for mos. No. 180, 1 refill):

Is prescriber requesting:  Brand  Generic  Either Acceptable (check one)

Off formulary? Yes  No

Condition (text only, no codes) \_\_\_\_\_

Is this enrollee deemed 'At Risk'? Yes  No

If yes, is the enrollee appealing a limitation, or the continuation of a limitation, on access to coverage for frequently abused drugs (i.e., an enrollee specific point-of-sale (POS) edit, the selection of a prescriber and/or pharmacy for purposes of lock-in); or information sharing for subsequent Part D plan enrollments. Yes  No

**Prospective Requests:**

Has Enrollee purchased the drug pending appeal? Yes  No

If Yes: Date Purchased: Amount Paid:

Purchased from a network pharmacy? Yes  No

**Retrospective Requests:**

Date(s) of Purchase: Amount(s) Paid: Drug Tier:

Purchased from a network pharmacy? Yes  No

If No, explain:

Has this drug been approved as requested? Yes  No

**Drug Benefit Denial Rationale:**

- |  |  |
|--|--|
| <input type="checkbox"/> Utilization management rules not met  | <input type="checkbox"/> Out-of-Network rules not met        |
| <input type="checkbox"/> Off-formulary exception rules not met | <input type="checkbox"/> Covered under A/B                   |
| <input type="checkbox"/> Tiering exception rules not met       | <input type="checkbox"/> Cost-sharing dispute                |
| <input type="checkbox"/> Excluded drug/use                     | <input type="checkbox"/> Not a Medically Accepted Indication |
| <input type="checkbox"/> Drug is not FDA approved              | <input type="checkbox"/> Other:                              |

**Prescriber Information:**

**Name of Physician/Prescriber:**

**Office Address:**

**Phone Number:**

**Fax Number:**

**Exhibits:** *Label applicable exhibits with letters provided below, and place them in order by letter.*

**Procedural Documents:**

- A.** Case Narrative cover page that presents an overview of the appeal: Describe the issue on appeal; identify all relevant information; Identify all relevant information; Identify the arguments presented in favor of coverage; and Explain the Plan rationale for denial.
- B.** Request for Coverage Determination and Plan Coverage Determination Decision Notice
- C.** Request for Coverage Redetermination and Plan Redetermination Decision Notice
- D.** Prescriber Statement (for exceptions requests)
- E.** Prior Authorization Form or Exception Request Form
- F.** Representation Documents (AOR or other writing, DPOA/POA, Healthcare Proxy, Surrogate for an incompetent enrollee under State Law, estate representative)
- G.** Other (describe or list below additional exhibits the Plan considers important)

**Evidentiary Documents:**

- H.** Part D Plan Formulary (relevant exceptions and/or coverage criteria)
- I.** Part D Plan Evidence of Coverage or other Subscriber Materials (relevant portions)
- J.** Cost-Sharing Information (copies of internal Plan documents/screens showing TrOOP or other cost-sharing information as relevant to the dispute)
- K.** Medical Records (separated by physician, labeled, and in chronological order with most recent on top)
- L.** Medicare Rules (Medicare law and regulations, CMS manuals, and/or CMS program guidance as relevant to the Part D Plan's determination)
- M.** Redetermination Evidence (evidence submitted by the appellant and/or the prescriber, and internal Plan medical reviews conducted to evaluate medical necessity issues)
- N.** Other (describe or list additional exhibits the Plan considers important).