PART D QIC DRUG APPEAL
CASE FILE TRANSMITTAL FORM

Appeal Information

(Check one for each line)

a.	**Priority:**	☐ **Expedited**	☐ **Standard**
b.	**Appeal Type:**	☐ **Prospective**	☐ **Retrospective**
c.	**Out of Compliance:** *(Auto-forward)*	☐ **Yes**	☐ **No**

Requestor Name:

Enrollee Name:

Enrollee Health Insurance Card Number/ Medicare Claim Number:

Date of Birth:

Enrollee Address:

Enrollee Telephone Number:

Enrollee requires the Reconsideration Notice in a language other than English?

No ☐ **Yes** ☐

Language needed:

Part D Plan Information

Plan Type:

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

Plan Contract Number: E#

Enter 4 digit C.M.S. Plan Number:

Plan Identification Number:

Formulary Name/Formulary ID #

Plan Contact Name and Title:

Contact Phone Number:

Fax Number:

Email Address:

Plan Address:

Representative Appeals: *(***NOTE: Representative documents MUST be included in case file***)*

Name of Representative:

Address:

Phone Number:

Fax Number:

Email Address:

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** ☐

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

Plan Level 0: Coverage Determination:

Coverage Determination (CD):
Date Coverage Determination requested:
Did Appellant ask Plan to expedite? **Yes** ☐ **No** ☐
Did 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 Appellant ask plan to expedite? **Yes** ☐ **No** ☐
Did Plan grant an expedited review? **Yes** ☐ **No** ☐
Decision Date:
Was RD untimely? **Yes** ☐ **No** ☐

Drug Benefit in Dispute:

Name of Drug:
Strength/ Dosage/ Amount/ Refill Number (e.g. 20 mg BID for 3 mos. No. 180, 1 refill):
Is prescriber requesting: ☐ **Brand** ☐ **Generic** ☐ **Either Acceptable** (check one)
Off formulary? **Yes** ☐ **No** ☐
Prospective Requests:
Has Enrollee purchased the drug pending appeal? **Yes** ☐ **No** ☐
If YES: **Date Purchased** **Amount paid:**
Purchased from 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:

Drug Benefit Denial Rationale:

- ☐ **Utilization management rules not met**
- ☐ **Off-formulary exception rules not met**
- ☐ **Tiering exception rules not met**
- ☐ **Excluded drug/ use**
- ☐ **Not FDA approved**
- ☐ **Out-of-Network rules not met**
- ☐ **Covered under A/ B**
- ☐ **Cost-sharing dispute**
- ☐ **Not a Medically Accepted Indication**
- ☐ **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 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 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 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 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).