

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
1. Is this auto-forward in relation to an at-risk determination? Yes No
- f. Is this a prior authorization appeal? Yes No
1. If yes, Has the plan chosen to waive or relax PA requirements due to COVID-19? Yes No
2. If the plan has chosen to waive or relax PA requirement due to COVID-19, the plan must submit any prior authorization flexibilities and the applicable timeframes the plan may have used in their coverage review.

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).