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

f. **Is this a prior authorization appeal?** ☐ Yes ☐ No

NOTE: Due to COVID-19 the plan must submit any prior authorization flexibilities and the applicable timeframes the plan may have used/ utilized in their coverage reviews

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:

☐ **Utilization management rules not met**

☐ **Off-formulary exception rules not met**

☐ **Tiering exception rules not met**

☐ **Excluded drug/use**

☐ **Drug is 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 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).