

## 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  Dismissal
- c. Applicable Coverage Year(s): \_\_\_\_\_
- d. Does this case involve a cost sharing issue?  Yes  No
- e. Is this case an auto forward due to the plan missing the adjudication time frame?  Yes  No
- f. Is this case an auto forward of an adverse drug management program appeal?  Yes  No

### 2. Enrollee Data:

Enrollee Name (First/Last): \_\_\_\_\_ Enrollee HICN or Enrollee MBI: \_\_\_\_\_

Enrollee Date of Birth: \_\_\_\_\_ Enrollee Phone: \_\_\_\_\_

Enrollee Street: \_\_\_\_\_

Enrollee City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

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?  Yes  No

If 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 prescriber/physician  Enrollee's treating prescriber/non-physician
- Enrollee's estate Is estate documentation in file?  Yes  No
- Representative Is an AOR or Power of Attorney document in file?  Yes  No
- Surrogate acting in accordance with state law

#### 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: \_\_\_\_\_

Dosage/Frequency/Route of Administration/Quantity (e.g., 20 mg BID, PO or oral, #30) \_\_\_\_\_

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

Off formulary?  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: (Plan Substantive Decision)**

- |                                                              |                                                                                                                                |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> At-risk determination               | <input type="checkbox"/> Off-formulary exception rules not met                                                                 |
| <input type="checkbox"/> Cost-sharing dispute                | <input type="checkbox"/> Out-of-Network rules not met                                                                          |
| <input type="checkbox"/> Covered under A/B                   | <input type="checkbox"/> Tiering exception rules not met                                                                       |
| <input type="checkbox"/> Drug is not FDA approved            | <input type="checkbox"/> Utilization management (UM) rules not met                                                             |
| <input type="checkbox"/> Excluded drug/use                   | <i>(Choose one of the following if UM selected)</i>                                                                            |
| <input type="checkbox"/> Not a medically accepted indication | <input type="checkbox"/> Prior Authorization <input type="checkbox"/> Step Therapy <input type="checkbox"/> Dosage Restriction |
|                                                              | <input type="checkbox"/> Other _____                                                                                           |

**Prescriber Information:**

Name of Physician/Prescriber: \_\_\_\_\_

Office Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Drug Benefit Dismissal Denial Rationale: (Plan Procedural Decision)**

- Bene Died During Appeal Process       Not a Proper Party       Not a Valid Request  
 Untimely Filing       Unknown       Withdrawn

**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.** Copy Enrollee Dismissal Letter
- H.** Other (describe or list below additional exhibits the Plan considers important)

**Evidentiary Documents:**

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

**Additional Evidentiary and Procedural Documents For At-Risk Determinations:**

- P.** Plan DMP policies/procedures
- Q.** Enrollee Case Management Documentation - OMS/MARx Notifications/Reports, Prior Plan Information, Limitations/Edits for FADs, Prescriber Notice(s), Prescriber Response(s) to Inquiries, Prescriber Verification of PARB/ARB Status
- R.** Enrollee Notices – Initial and Second Notices
- S.** Documentation on Selecting Prescriber/Pharmacy Limitations (e.g., Beneficiary Access, Beneficiary Preference, Prescriber/Pharmacy Notifications and Acceptance Confirmation)
- T.** Any Other Relevant Documentation/Information