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 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 Name) _____ (Last Name) **Enrollee HICN or Enrollee MBI:** _____

Enrollee Phone: _____

Enrollee Street: _____

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** ☐

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:

☐ At-risk determination

☐ Cost-sharing dispute

☐ Covered under A/B

☐ Drug is not FDA approved

☐ Excluded drug/use

☐ Not a medically accepted indication

☐ Off-formulary exception rules not met

☐ Out-of-Network rules not met

☐ Tiering exception rules not met

☐ Utilization management (UM) rules not met

(Choose one of the following if UM selected)

☐ Prior Authorization ☐ Step Therapy ☐ Dosage Restriction

☐ 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).

Additional Evidentiary and Procedural Documents For At-Risk Determinations:

- ☐ **O.** Plan DMP policies/procedures
- ☐ **P.** 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
- ☐ **Q.** Enrollee Notices – Initial and Second Notices
- ☐ **R.** Documentation on Selecting Prescriber/Pharmacy Limitations (e.g., Beneficiary Access, Beneficiary Preference, Prescriber/Pharmacy Notifications and Acceptance Confirmation)
- ☐ **S.** Any Other Relevant Documentation/Information

Clear Form