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)

☐ 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: _____

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

Clear Form