

Model Redetermination Notice of Denial of Medicare Prescription Drug Coverage

Date:

Enrollee's name: *<Insert Name>*
<Street Address>
<City, State Zip Code>

Enrollee's ID Number: *<Insert Number>*

Plan Name: *<Insert Plan Name>*

Contract ID: *<Insert Contract ID>*

Formulary ID: *<Insert Formulary ID>*

Plan ID: *<Insert Plan ID>*

We agree with our initial coverage determination and are denying the following prescription drug(s) that you or your physician or other prescriber requested: *<Insert name of prescription drug(s)>*

We denied this request because: *<Insert the specific reason for denial and a description of any applicable Medicare coverage rule or any other applicable plan policy upon which the denial was based, including any specific formulary criteria that must be satisfied for approval. If the drug could be approved under the exception rules, the notice must explicitly state the need for a supporting statement and clearly identify the type of information that should be submitted when seeking a formulary or tiering exception.>*

What If I Don't Agree With This Decision?

You have the right to ask for an independent review (appeal) of our decision. If your case involves an exception request and your physician or other prescriber did not already provide your plan with a statement supporting your request, **your physician or other prescriber must provide a statement to support your exception request and you should attach a copy of this statement to your appeal request.** If you want to appeal our decision, you must request your appeal in writing within 60 calendar days after the date of this notice. You must mail or fax your written request to the independent reviewer at:

MAXIMUS Federal Services
3750 Monroe Ave., Suite #703
Pittsford, NY 14534-1302

Toll-free Phone: (877) 456-5302

Fax Numbers:

Toll-free: (866) 825-9507

(585) 425-5301

Who May Request an Appeal?

You, your prescriber, or someone you name to act for you (your representative) may request an appeal. If someone requests an appeal for you, he or she must send proof of his or her right to represent you with the request form. Proof could be a power of attorney, a court order, or an Appointment of Representation form. If the person appealing is your prescriber or is authorized under state law to act for you, an Appointment of Representation is not needed.

You can call us at: () _____ to learn how to name your representative. If you have a hearing or speech impairment, please call us at TTY () _____.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

For more information about your appeal rights, call us or see your Evidence of Coverage.

There Are Two Kinds of Appeals You Can Request

Expedited (72 hours)

You can request an expedited (fast) appeal for cases that involve coverage, if you or your doctor believes that your health could be seriously harmed by waiting up to 7 days for a decision. If your request to expedite is granted, the independent reviewer must give you a decision no later than 72 hours after receiving your appeal (the timeframe may be extended in limited circumstances).

- **If the doctor who prescribed the drug(s) asks for an expedited appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 7 days could seriously harm your health, the independent reviewer will automatically expedite the appeal.**
- If you ask for an expedited appeal without support from a doctor, the independent reviewer will decide if your health requires an expedited appeal. If you do not get an expedited appeal, your appeal will be decided within 7 days.
- Your appeal will not be expedited if you've already received the drug you are appealing.

Standard (7 days)

You can request a standard appeal for a case involving coverage or payment. The independent reviewer must give you a decision no later than 7 days after receiving your appeal (the timeframe may be extended in limited circumstances).

When the Independent Reviewer Can Extend the Timeframe for Making a Decision

The timeframe may be extended if your case involves an exception request and we have not received the supporting statement from your doctor or other prescriber supporting the request. The timeframe also may be extended when the person acting for you files an appeal request but does not submit proper documentation of representation. In both situations, the independent reviewer may toll (or stop the clock) for up to 14 days to get this information.

How Do I Request an Appeal?

You, your prescriber, or your representative should mail or fax your written appeal request to:

[Insert Part D QIC address and fax number]

What Do I Include with My Appeal?

You should include your name, address, member ID number, the reasons for appealing, and any evidence you wish to attach. If the appeal is made by someone other than you or your doctor or other prescriber, the person must submit a document appointing him or her to act for you.

If your appeal relates to a decision by us to deny a drug that is not on our list of covered drugs (formulary) or if you are asking for an exception to a prior authorization (PA) or other utilization management (UM) requirement, your prescribing doctor or other prescriber must submit a statement with your appeal request indicating that all the drugs on any tier of our formulary (or the PA/UM requirement) would not be as effective to treat your condition as the requested drug, or would harm your health.

What Happens Next?

If you appeal, the independent reviewer will review your case and give you a decision. If any of the prescription drugs you requested are still denied, you can appeal to an administrative law judge (ALJ) if the value of your appeal is at least *[insert AIC amount]*. If you disagree with the ALJ decision, you will have the right to further appeal. You will be notified of your appeal rights if this happens.

If You Need Information or Help call us at:

Toll Free:

TTY:

Other Resources To Help You

Medicare Rights Center

Toll Free: 1-888-HMO-9050 (1-888-466-9050)

TTY:

Elder Care Locator

Toll Free: 1-800-677-1116

1-800-MEDICARE (1-800-633-4227)