April 4, 2022

to: Grievances and Appeals Fax: 866-273-3692

from: Donald Mayor

subject: Medication Denial Appeal– Reference Number 79802821

Dear Appeals Department;

This letter is intended to appeal the decision made to deny the cost of the medication. On 3/23/202 Anthem denied my doctors request for the medication VICTOZA 2-Pak 18 MG/3ML pen. The reason indicated on the letter was, medical necessity.

This is decision is clearly not made by looking at the patient's full medical history. I, Kelly Keesee, am the patient. Let me explain the medical necessity. Both of my parents are insulin resistant diabetics. My father's diabetes is so bad, that he has now lost a limb. My Aunt on my mom's side has diabetes so bad that she has issues with her vision and her limps on a regular basis.

I have had PCOS since I was 17, which also creates insulin resistance. I was diagnosed and treated with type 2 diabetes with my last pregnancy in 2015. By all indications, I will be a lifelong diabetic. This will not be cured. Metformin has been used by my OBGYN, due to digestive issues, I had to come off. Januvia has helped but in over a year has not brought my A1C into normal range, with diet changes. I am also considered morbidly obese and have a list of other medical issues.

To say that this medication is not medically necessarily, is appalling to the healthcare system. Its as if you are saying you will not support prevented care for me to get my diabetes under control, but instead I must wait until my sugar is 400 and my A1C is high before you will treat me, so I need to get worse before you will provide the necessary tools for me to get better?

It is because of the many reasons I listed above that I appeal this decision and I hope that you will approve the request for medication VICTOZA to help better my health now, instead of trying to play catchup in the future.

Thank You,

Donald Mayor

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Anthem Blue Cross and Blue Shield and its Affilate HealthKeepers, Inc.
P.O. Box 34255
San Antonio TX 78265-4255

Anthem
And Its Affiliate HealthKeepers, Inc.

03/23/2022

DONALD MAYOR
123 RAY STREET
VIRGINIA BEACH, VA 24080

Confidential UM Information for:
Member Name:DONALD MAYOR
Date of Birth: 09/10/1991
Date Created: 03/22/2022
Reference Number: 79802821
Medication: VICTOZA 2-PAK 18 MG/3 ML PEN
Provider: Karen Hill
Denial Reason: Medical Necessity

Important information about the request you or your doctor asked us to review.

IngenioRx, Inc. provides utilization management services for Anthem Blue Cross and Blue Shield and its affiliate HealthKeepers, Inc.

Dear DONALD MAYOR:

Recently, you or your doctor asked us to review a request for medication. We reviewed the request and it is not approved. We'd like to explain why.

We denied your request because we did not see what we need to approve the drug you

asked us to pay for, (Victoza). We may be able to approve this drug in a certain situation (for those who are not using the requested drug for the treatment of prediabetes [A1C less than 6.5 percent (%)]). We do not see that this applies to you. If this applies to you, we may need more information (if the drug will be used for certain reasons; if you have tried other drugs first; if you cannot use certain drugs; if your kidneys are not working well). We based this decision on your health plan's prior authorization clinical criteria named Glucagon-Like Peptide-1 (GLP-1) Receptor Agonist Step Therapy.

Medications that are not medically necessary are an exclusion under your plan benefits and are not covered.

You Should Know
It might help you better understand how your plan works if you know how the decision was made.

This review was completed by Janushi Pandya, PharmD. They can be reached by phone at 833-293-0659. They consider many things when making a decision:

- Your health status
- Clinical criteria or guidelines
- Your health plan
- They may also consider the latest findings in medical journals and proven research

There are several ways you, your provider or your authorized representative can get a free copy of the clinical criteria mentioned above.

- Plan clinical criteria
- Log into www.anthem.com/pharmacyinformation.
- Call the number on your identification card

Please refer to the definition and exclusion sections of your plan benefits for information on medically necessary services.

What's Next

- This decision means this medication is not covered by your health plan. It doesn't mean that you should stop getting medical care. Only you and your doctor can decide what's best for you. If you have any questions about your benefits, you can call the Member Service number on your ID card.
- You can appeal this decision if you or your provider disagrees with it. We're including appeal information with this letter.
- We've told your provider about this decision and they'll receive the information in this letter. If they'd like to provide more information about your case, they can call our clinical reviewer at 833-293-0659.

Rights Available to Members

If you do not agree with our adverse decision, you have the right to request an appeal. Unless your description of benefits states otherwise, you must request an appeal within 180 calendar days of the date you were notified of our adverse decision. Your provider, or any other person you choose, may appeal on your behalf. They may also help you during the appeal process. If you ask someone to represent or help you, please give them a signed authorization to include with the appeal.

How do I request an expedited appeal?

If you have not had services (pre-service), or if you are now receiving services (concurrent), an appeal may be handled in an expedited manner if you, or your provider, believe that the condition could seriously jeopardize your life, health, or ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without care or treatment by waiting for the appeal to be resolved using standard appeal time frames. To request an expedited appeal, you, your provider or your representative can call 1-833-592-9956 or send a written request to the following address: Grievances and Appeals, P.O. Box 29384, Richmond, VA 24958. Unless your description of benefits states otherwise, we will respond to expedited appeal requests within 72 hours.

If you are a member of a self-funded non-grandfathered health plan, as defined by the Patient Protection and Affordable Care Act (PPACA), you may request an expedited external review instead of, or at the same time as, exercising the expedited appeal process with your plan. To request an expedited external review, you, your provider or your representative can call 1-833-592-9956. If you prefer, you may send your written request, and any additional supporting documentation, to the following address: Grievances and Appeals, P.O. Box 29384, Richmond, VA 24958.

How do I request a standard appeal?

To request a pre-service appeal, or to request an appeal for services you have already had (post-service), send a written request to the following address: Grievances and Appeals, P.O. Box 29384, Richmond, VA 24958. Instead of mailing your written request, you also have the option to fax it toll free to 866-273-3692. We encourage you to request appeals in writing. However, unless your description of benefits states otherwise, you may submit your appeal verbally by contacting customer service at the telephone number on your health plan identification card. Unless your description of benefits states otherwise, appeals of adverse decisions are resolved and a written response will be sent to you within a reasonable period of time appropriate to the medical circumstances but not later than 30 calendar days.

What should my appeal include?

You may include, if available, the following information with your appeal: the member's name and identification number; the name of the provider or facility who will or has provided care; date(s) of service; the claim or reference number for the specific decision with which you do not agree; and the

specific reason(s) why you do not agree with the decision. You have the right, and we encourage you, to submit written comments, documents or other relevant information with your appeal.

How will my appeal be handled?

The appropriate administrative and/or clinical specialists will review your appeal. All relevant information submitted by you or on your behalf will be reviewed regardless of whether it was considered at the time the initial decision was made. We may contact any providers who may have additional information to support your appeal. The reviewers will not have been involved in the initial decision. They also will not be a subordinate of the person who made the initial decision.

If I disagree with the decision on my appeal, what other rights do I have?

If we deny your appeal, you will be provided with other dispute resolution options as applicable. If you are a member of a self-funded non-grandfathered health plan, as defined by PPACA, you may have the right to request an independent external review of our decision. Please refer to your description of benefits or contact customer service at the telephone number on your health plan identification card for detailed information regarding the entire appeal process.

ERISA Plan Members

If your health benefit plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), once you have exhausted all mandatory appeal rights, you have the right to bring a civil action in federal court under section 502(a)(1)(B) of ERISA within one year, unless your plan provides for a longer period. Check your benefits booklet or plan documents to see if you have more time.