Part D - Case File Transmittal Form

Temporary Appeal Number : **Q19-00000978**
Submission Received: **Fri Aug 16, 2019 at time 6:01 PM ET**

Appeal Information:

Appeal Priority: **Expedited**
Appeal Type: **Prospective**
Is this case an Auto-Forward?: **Yes**
QIC Appeal Number: **N/A**
Applicable Coverage Year(s): **2000**
Does this case involve a cost sharing issue?: **Yes**

Auto-Forward :

Please select the level at which the processing time was missed: **Coverage Determination**

Health Plan Info :

Contract Number: **12333**
Plan Name: **ABC Entity**
Plan Type: **Other**
Other: **sHyTfIanHyS1**
Plan Id: **1United Health Care08162019 1500**
Formulary Name/ID: **1Formulary Id08162019 1500**

The Health Plan Contact Information :

First Name: **Addison**
Last Name: **Sutter**
Address Line 1: **N/A**
Address Line 2 (Optional): **N/A**
City: **N/A**
State: **N/A**
Zip Code: **N/A**
Email Address: **addison@sutter.com**
Phone:
Decision Letter Fax: **916-503-5014**
Request for Information Fax: **916-503-5014**

Requestor Information

Select Requestor: **Enrollee's Prescribing Physician**
Is estate documentation in the file?: **N/A**
Is an AOR or Power of Attorney in the File?: **N/A**

Representative Information

First Name: **N/A**
Last Name: **N/A**
Address Line 1: **N/A**
Address Line 2 (Not Required): **N/A**

City: **N/A**
State: **N/A**
Zip Code: **N/A**
Email Address: **N/A**
Phone: **N/A**
Fax Number: **N/A**

Plan Attestation for Representative

"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."
Portal User: **N/A**

Enrollee Information

First Name: **1Enrollee First Name08162019 1500**
Last Name: **1Enrollee Last Name08162019 1500**
Address Line 1: **1Enrollee Address108162019 1500**
Address Line 2 (optional):
City: **1Los Angeles08162019 1500**
State: **HI**
Zip Code: **47373-3348**
Phone: **264-057-5894**
Medicare Number (MBI) : **MBINSXjE30o**
Health Insurance Claim #: **N/A**

Language preference

Does the Enrollee require the Reconsideration Notice to be in a language other than English?**No**
Please select a language:**N/A**
Other Language:**N/A**

Communication Preference

Does the Enrollee require communication be made in any alternate format?**No**
Required Format: **N/A**
Font Size:**N/A**
Other:**N/A**

Plan level

Plan Level 0 Coverage Determination

Date Coverage Determination was requested: **Tue May 28, 2019**
Decision Date: **N/A**
Was Coverage Determination untimely? :**Yes**
Was a decision made at this level? :**No**
Did appellant ask the Plan to expedite?: **Yes**
Did the Plan grant an expedited review?: **No**

Exceptions

Does the determination involve an Exceptions Request?: **N/A**

Did the Plan extend the maximum time frames to obtain a prescriber statement?: **N/A**

Date prescriber statement was requested: **N/A**

Was it received?: **N/A**

Date prescriber statement was received: **N/A**

Plan Level 1 Redetermination

Date Redetermination was requested: **N/A**

Decision Date: **N/A**

Was Coverage Determination untimely? :**N/A**

Was a decision made at this level?: **N/A**

Did appellant ask the Plan to expedite?: **N/A**

Did the Plan grant an expedited review?: **N/A**

Prescriber Information

First Name: **1Prescriber First Name08162019 1500**

Last Name: **1Prescriber Last Name08162019 1500**

Suffix:

Address Line 1: **1Prescriber Address08162019 1500**

Address Line 2 (Not Required):

City: **1Prescriber City08162019 1500**

State: **WV**

Zip Code: **47373-3348**

Office Phone Number: **588-973-2304**

Office Fax Number: **175-418-4820**

Drug Details (Drug Benefits in Dispute)

Number: 1

National Drug Code (NDC): **3595806790**

Drug Name: **1Drug Name08162019 1500**

Strength/ Dosage/ Amount: **120mg08162019 1500/ 15ml08162019 1500/**

Type: **both**

Off-Formulary: **No**

Denial Rationale: **Tiering exception rules not met**

Explanation of Rationale: **N/A**

What type of coverage is requested for this drug?: **Retrospective**

Has the Enrollee purchased the Drug pending appeal?: **N/A**

Was the Drug(s) purchased from a network pharmacy?: **Yes**

Explanation: **N/A**

Number	Date(s) of Purchase	$ Amount Paid	Drug Tier
1	Tue May 28, 2019	1000.00	two

Has this drug been approved as requested?: **No**

Exhibit Instructions

Procedural Documentations

☐ A. Case Narrative cover page the presents an overview of the appeal: Describe the issue on the appeal; Identify all relevent information;Identify arguments presented in favor of coverage; and explain the Plain rationale for denial
☑ B. Request for Coverage Determination and Plan Coverage Decision Notice
☐ C. Request for Redetermination and Plan Redetermination Decision Notice
☐ D. Prescriber statement (for exception 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 (additional documents the Plan considers important)

Evidentiary Documentation

☑ H. Part D Plan Comprehensive Formulary for Plan year(s) at issue
☐ I. Part D Plan Evidence of Coverage or other subscriber materials for Plan year(s) at issue
☐ J. Cost Sharing Information (copies of internal Plan documents/ screens showing TrOOp or other relevant cost-sharing information)
☐ K. Medical Records
☐ L. Medicare Rules (Medicare law and regulations, CMS manuals, and/or CMS program guidance as relevant to the Pard D Plan's Determination)
☐ M. Redetermination Evidence (evidence submitted by appellant and /or prescriber, and internal Plan medical reviews conducted to evaluate medical issues)
☐ N. Universal Claim form for a compound drug
☑ O. Other (additional documents the Plan considers important)

Overview of Issues:

1Overview08162019 1500

Timeline of Facts:

1TimelineFacts08162019 1500