

## **Part D - Case File Transmittal Form**

Temporary Appeal Number : **Q19-00001250**

Submission Received: **Wed Oct 30, 2019 at time 2:46 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, 2019, 2001**

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: **455**

Plan Name: **Helathy Blue**

Plan Type: **PDP**

Other: **N/A**

Plan Id: **1United Health Care10302019 1144**

Formulary Name/ID: **1Formulary Id10302019 1144**

### **The Health Plan Contact Information :**

First Name: **Ginu**

Last Name: **John**

Address Line 1: **123 long street**

Address Line 2 (Optional):

City: **Milpitas**

State: **CA**

Zip Code: **12312-3123**

Email Address: **johngeethu+qicportal@gmail.com**

Phone: **408-644-4905**

Decision Letter Fax: **234-234-2342**

Request for Information Fax: **242-432-4234**

### **Requestor Information**

Select Requestor: **Enrollee**

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 Name10302019 1144**  
Last Name: **1Enrollee Last Name10302019 1144**  
Address Line 1: **1Enrollee Address110302019 1144**  
Address Line 2 (optional):  
City: **1Los Angeles10302019 1144**  
State: **ME**  
Zip Code: **20756-4058**  
Phone: **932-104-1305**  
Date of Birth (MM/DD/YYYY): **03/03/1990**  
Medicare Number (MBI) : **MBI8JhFb1OU**  
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: **Sun Aug 11, 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 Name10302019 1144**

Last Name: **1Prescriber Last Name10302019 1144**

Suffix:

Address Line 1: **1Prescriber Address10302019 1144**

Address Line 2 (Not Required):

City: **1Prescriber City10302019 1144**

State: **MD**

Zip Code: **20756-4058**

Office Phone Number: **545-179-8937**

Office Fax Number: **910-816-6960**

## Drug Details (Drug Benefits in Dispute)

Number: **1**

National Drug Code (NDC): **5395638533**

Drug Name: **1Drug Name10302019 1144**

Strength/ Dosage/ Amount: **120mg10302019 1144/ 15ml10302019 1144/**

Type: **generic**

Off-Formulary: **No**

Is this enrollee deemed 'At Risk'?: **Yes**

Is the enrollee appealing a limitation, or the continuation of a limitation, on access to coverage for frequently abused drugs (i.e., an enrollee specific point-of-sale (POS) edit, the selection of a prescriber and/or pharmacy for purposes of lock-in); or information sharing for subsequent Part D plan enrollments.: **Yes**

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	Sun Aug 11, 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 relevant 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 Part 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:

**1Overview10302019 1144**

Timeline of Facts:

**1TimelineFacts10302019 1144**