

Part D - Case File Transmittal Form

Temporary Appeal Number : **Q19-00001022**

Submission Received: **Tue Aug 20, 2019 at time 4:58 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, 2001, 2019**

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: **Cost**

Other: **N/A**

Plan Id: **1United Health Care08202019 1356**

Formulary Name/ID: **1Formulary Id08202019 1356**

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**

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 Name08202019 1356
Last Name: 1Enrollee Last Name08202019 1356
Address Line 1: 1Enrollee Address108202019 1356
Address Line 2 (optional):
City: 1Los Angeles08202019 1356
State: PA
Zip Code: 48332-5742
Phone: 424-821-0508
Medicare Number (MBI) : MBInmwecqvoQ
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: Sat Jun 01, 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 Name08202019 1356**
Last Name: **1Prescriber Last Name08202019 1356**
Suffix:
Address Line 1: **1Prescriber Address08202019 1356**
Address Line 2 (Not Required):
City: **1Prescriber City08202019 1356**
State: **PW**
Zip Code: **48332-5742**
Office Phone Number: **633-454-1776**
Office Fax Number: **243-653-1557**

Drug Details (Drug Benefits in Dispute)

Number: **1**
National Drug Code (NDC): **6785255518**
Drug Name: **1Drug Name08202019 1356**
Strength/ Dosage/ Amount: **120mg08202019 1356/ 15ml08202019 1356/**
Type: **brand**
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	Sat Jun 01, 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:

1Overview08202019 1356

Timeline of Facts:

1TimelineFacts08202019 1356