

Part D - Case File Transmittal Form

Temporary Appeal Number : **Q19-00001242**

Submission Received: **Mon Aug 05, 2019 at time 6:08 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: **12234**

Plan Name: **234**

Plan Type: **Other**

Other: **Ru99QPZlh7U9**

Plan Id: **1United Health Care08052019 1508**

Formulary Name/ID: **1Formulary Id08052019 1508**

The Health Plan Contact Information :

First Name: **Ashok**

Last Name: **Ambrose**

Address Line 1: **Kilgore Rd**

Address Line 2 (Optional):

City: **Rancho Cordova**

State: **CA**

Zip Code: **54645-6455**

Email Address: **ashok+6@gmail2.com**

Phone: **546-546-4646**

Decision Letter Fax: **234-242-4242**

Request for Information Fax: **546-545-6465**

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 Name08052019 1508**
Last Name: **1Enrollee Last Name08052019 1508**
Address Line 1: **1Enrollee Address108052019 1508**
Address Line 2 (optional):
City: **1Los Angeles08052019 1508**
State: **IA**
Zip Code: **21857-1958**
Phone: **320-767-3190**
Medicare Number (MBI) : **MBIF3CxsMyv**
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: **Fri May 17, 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 Name08052019 1508**
Last Name: **1Prescriber Last Name08052019 1508**
Suffix:
Address Line 1: **1Prescriber Address08052019 1508**
Address Line 2 (Not Required):
City: **1Prescriber City08052019 1508**
State: **MT**
Zip Code: **21857-1958**
Office Phone Number: **253-393-9551**
Office Fax Number: **573-445-5673**

Drug Details (Drug Benefits in Dispute)

Number: 1
National Drug Code (NDC): **0880271527**
Drug Name: **1Drug Name08052019 1508**
Strength/ Dosage/ Amount: **120mg08052019 1508/ 15ml08052019 1508/**
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	Fri May 17, 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:

1Overview08052019 1508

Timeline of Facts:

1TimelineFacts08052019 1508