Part D - Case File Transmittal Form

Temporary Appeal Number : **Q19-00000896**
Submission Received: **Tue Jul 16, 2019 at time 3:54 PM ET**

Appeal Information:

Appeal Priority: **Expedited**
Appeal Type: **Prospective**
Is this case an Auto-Forward?: **No**
QIC Appeal Number: **1-608599568**
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: **N/A**

Health Plan Info :

Contract Number: **qa123456**
Plan Name: **Test lk Legal Entity Name**
Plan Type: **Employer Sponsored**
Other: **N/A**
Plan Id: **1United Health Care07162019 1253**
Formulary Name/ID: **1Formulary Id07162019 1253**

The Health Plan Contact Information :

First Name: **HealthPlan**
Last Name: **TestQa**
Address Line 1: **HealthPlan addr1**
Address Line 2 (Optional):
City: **HealthPlan City**
State: **HI**
Zip Code: **96325-6666**
Email Address: **healthplan@gmail2.com**
Phone: **916-333-2222**
Decision Letter Fax: **916-333-2229**
Request for Information Fax: **916-333-2224**

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 Name07162019 1253**
Last Name: **1Enrollee Last Name07162019 1253**
Address Line 1: **1Enrollee Address107162019 1253**
Address Line 2 (optional):
City: **1Los Angeles07162019 1253**
State: **IN**
Zip Code: **87898-2115**
Phone: **989-774-4913**
Medicare Number (MBI) : **MBIDU9Oe07E**
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 Apr 27, 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: **Sat Apr 27, 2019**

Decision Date: **Sat Apr 27, 2019**

Was Coverage Determination untimely? :**Yes**

Was a decision made at this level?: **Yes**

Did appellant ask the Plan to expedite?: **Yes**

Did the Plan grant an expedited review?: **Yes**

Prescriber Information

First Name: **1Prescriber First Name07162019 1253**

Last Name: **1Prescriber Last Name07162019 1253**

Suffix:

Address Line 1: **1Prescriber Address07162019 1253**

Address Line 2 (Not Required):

City: **1Prescriber City07162019 1253**

State: **MT**

Zip Code: **87898-2115**

Office Phone Number: **229-878-3526**

Office Fax Number: **362-361-5614**

Drug Details (Drug Benefits in Dispute)

Number: 1

National Drug Code (NDC): **7396799626**

Drug Name: **1Drug Name07162019 1253**

Strength/ Dosage/ Amount: **120mg07162019 1253/ 15ml07162019 1253/**

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?: **Prospective**

Has the Enrollee purchased the Drug pending appeal?: **No**

Was the Drug(s) purchased from a network pharmacy?: **N/A**

Explanation: **N/A**

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:

1Overview07162019 1253

Timeline of Facts:

1TimelineFacts07162019 1253