

Part D - Case File Transmittal Form

Temporary Appeal Number : **Q19-00000913**

Submission Received: **Wed Jul 31, 2019 at time 2:19 PM ET**

Appeal Information:

Appeal Priority: **Expedited**

Appeal Type: **Prospective**

Is this case an Auto-Forward?: **No**

QIC Appeal Number: **1-008073963**

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 Care07312019 1118**

Formulary Name/ID: **1Formulary Id07312019 1118**

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 Name07312019 1118
Last Name: 1Enrollee Last Name07312019 1118
Address Line 1: 1Enrollee Address107312019 1118
Address Line 2 (optional):
City: 1Los Angeles07312019 1118
State: NY
Zip Code: 89198-0612
Phone: 380-204-0390
Medicare Number (MBI) : MB1gb1iuFoc
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 May 12, 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: **Sun May 12, 2019**

Decision Date: **Sun May 12, 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 Name07312019 1118**

Last Name: **1Prescriber Last Name07312019 1118**

Suffix:

Address Line 1: **1Prescriber Address07312019 1118**

Address Line 2 (Not Required):

City: **1Prescriber City07312019 1118**

State: **FL**

Zip Code: **89198-0612**

Office Phone Number: **378-535-9007**

Office Fax Number: **225-858-0698**

Drug Details (Drug Benefits in Dispute)

Number: **1**

National Drug Code (NDC): **4524020975**

Drug Name: **1Drug Name07312019 1118**

Strength/ Dosage/ Amount: **120mg07312019 1118/ 15ml07312019 1118/**

Type: **generic**

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 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:

1Overview07312019 1118

Timeline of Facts:

1TimelineFacts07312019 1118