

Part D - Case File Transmittal Form

Temporary Appeal Number : **Q19-00001021**

Submission Received: **Tue Aug 20, 2019 at time 4:54 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: **12333**

Plan Name: **ABC Entity**

Plan Type: **Cost**

Other: **N/A**

Plan Id: **1United Health Care08202019 1353**

Formulary Name/ID: **1Formulary Id08202019 1353**

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 1353**
Last Name: **1Enrollee Last Name08202019 1353**
Address Line 1: **1Enrollee Address108202019 1353**
Address Line 2 (optional):
City: **1Los Angeles08202019 1353**
State: **WI**
Zip Code: **92304-7307**
Phone: **370-066-3321**
Medicare Number (MBI) : **MBIkNCiIIHE**
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 1353**

Last Name: **1Prescriber Last Name08202019 1353**

Suffix:

Address Line 1: **1Prescriber Address08202019 1353**

Address Line 2 (Not Required):

City: **1Prescriber City08202019 1353**

State: **NH**

Zip Code: **92304-7307**

Office Phone Number: **706-682-4273**

Office Fax Number: **313-199-6676**

Drug Details (Drug Benefits in Dispute)

Number: **1**

National Drug Code (NDC): **6892348831**

Drug Name: **1Drug Name08202019 1353**

Strength/ Dosage/ Amount: **120mg08202019 1353/ 15ml08202019 1353/**

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 1353

Timeline of Facts:

1TimelineFacts08202019 1353