# MED D - CCR - Coverage Determinations and Redeterminations (Appeals)

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**Grievance Standard Verbiage:** Refer to the **Grievance Standard Verbiage (for use in Discussion with Beneficiary)** section in the appropriate work instruction linked in [MED D - Grievances Index (007931)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=71364003-a41f-4b84-be24-1e85435462b2).

**Description:** Provides the CCR with details necessary to assist a beneficiary with questions regarding a **new request** or **status update** for a Med D Coverage Determination or Redetermination, prescription cost, non-formulary medications, tiering exceptions, or prior authorizations and provide the appropriate resources to contact based on the beneficiary’s request.

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| Important Information |

Although a MED D plan has a specific formulary of covered medications, MED D beneficiaries can ask the plan to cover medications not included on the formulary or drugs that are on the formulary but have predetermined criteria.

* These initial requests are called Coverage Determinations.

If a beneficiary disagrees with the plan's decision, there are five (5) levels of appeals available to try to obtain coverage of medications.

* However, PBMs handle only the first level of appeals, also known as a Redetermination.

 Refer to the CIF for direction on the proper team to assist with CD&A questions.

**Notes:**

* Do NOT proactively offer Tiering or Formulary Exceptions unless otherwise directed in the document.
* There may be two lines of eligibility visible for migrating plans and in some cases, a transfer to a different Customer Care group may be required. Check the CIF for the correct process.
*  Unless otherwise noted, all phone numbers provided throughout the document are **internal only and should not** be provided to callers.

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| Appeals Overview |

 Information regarding Appeals—**including the phone number for C2C, IRE, etc.**—can **only** be provided to the beneficiary by the CD&A team because appeal requests may require a clinical review. Customer Care must submit an RM Task to the CD&A team. Refer to [Submitting an RM Task for CD&A](#_Submitting_an_RM).

An Appeal is a request by an enrollee, the enrollee’s representative, or the enrollee’s prescriber (if allowed by law) to review a denied Coverage Determination made by the Part D plan sponsor on the benefits under a Part D plan the enrollee believes he or she is entitled to receive or on any amounts the enrollee must pay for the drug coverage.

There are five (5) successive levels of appeals in the Medicare Part D program:

1. Redetermination

* Reviewed by CVS Caremark or Client (dependent upon whether the Client delegates Redeterminations to CVS Caremark)

1. Reconsideration

* Reviewed by an Independent Review Entity (IRE)

1. Administrative Law Judge (ALJ)

* Reviewed by a law judge

1. Medicare Appeals Council (MAC)
2. Judicial Review

* Reviewed by a Federal District Court

**Note:** To educate the beneficiary or provide information on the Appeals Process, refer to [Transfer to Coverage Determination (Escalations and Senior Team Only).](#_Transfer_to_Coverage)

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| Provider or Prescriber Calls |

Prescriber or provider calls for **coverage determinations and appeals** should be warm transferred to **1-877-827-7315 and select prompt 2**. For CD&A hours of operation, refer to [Phone Numbers (Contacts, Departments, Directory, Addresses, Hours, and Programs) (004378)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=f22eb77e-4033-4ad9-9afb-fc262f29faad).

* If after hours, Customer Care must submit an RM Task to the CD&A team. Refer to [Submitting an RM Task for CD&A](#_Submitting_an_RM).

**CCR Note:** Do not provide the above telephone numbers to a beneficiary. They are for provider and prescriber calls only. For beneficiary calls, refer to [Submitting an RM Task for CD&A](#_Submitting_an_RM).

If the beneficiary is calling to advise of a new provider or prescriber for an in-process CD request, refer to [Transfer to Coverage Determination (Escalations and Senior Team Only).](#_Transfer_to_Coverage)

Refer to the [HIPAA (Health Insurance Portability and Accountability Act) Grid – CVS (028920)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=5b354e50-0d15-42d0-b9c2-0711ea02d9ce) to ensure prescriber/provider guidelines are followed.

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| Authorized Persons Who Can Start or Check the Status of a Coverage Determination or Redetermination |

 Before beginning the process or checking the status of a Coverage Determination or Redetermination, the CCRs **MUST** verify they are speaking to one of the following individuals:

* Beneficiary
* Authenticated SHIP Counselor
* Physician or other Prescriber (includes representative of a prescriber's office or a representative of the prescriber)
* Power of Attorney (POA) or Appointed Representative (AOR)
* Legal Documentation MUST be viewable in PeopleSafe or FACETS to continue with the caller's request.
* Pharmacy
* The pharmacy is able to check the status of a Coverage Determination or Redetermination

If third-party is not authorized:

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| **Scenario 1:** The beneficiary is present and has authorized the third-party to speak on their behalf.  Any CD/Appeal would be handled in the same way it would be if speaking to the beneficiary (see [Decision Grid](#_Decision_Grid), below). | **Scenario 2:** The beneficiary is not present and/or third-party is not AOR or POA.  Educate the third-party that only the beneficiary has the right to file a CD/RD unless the third-party is an AOR or POA on the account. If no [AOR/POA (021424)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=4008954a-0d95-4ea9-add2-3a7dfa02c718) on file, offer to send form to third-party. |

Refer to the [MED D - Appointed Representative Form (AOR) or Power of Attorney (POA) (021424)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=4008954a-0d95-4ea9-add2-3a7dfa02c718).

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| CCR Checklist |

The following is a snapshot checklist of all the steps and decisions the CCR should consider that are outlined in the Decision Grid. This is **not** an all-inclusive list and must be used in combination with the [Decision Grid](#_Decision_Grid).

1. Member in Coverage Gap/Catastrophic Stage: CCR educates the caller.
2. **SilverScript PDP Members ONLY:** Drug on [Med D - Tiering Exception Exclusions - No Preferred Alternatives (010234)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=90c3c22e-86f7-46a9-934a-d5b17c67227d): CCR educates the caller.

 **Note:** Health Plans have different formularies and it is possible the beneficiary may not be in the Coverage Gap, and medication is not eligible for a Tiering Exception.

1. Run Test Claim to identify type of prescription:
2. Status of a Coverage Determination or Redetermination: CCR handles (Create a [CD&A RM Task](#_Submitting_an_RM) as needed).
3. Prior Authorization (Reject 75): Create a [CD&A RM Task](#_Submitting_an_RM).
4. Excluded by Med-D Law (Reject A5): CCR handles.
5. Lowest Cost Tier: CCR handles.
6. Not Lowest Cost Tier, Not Specialty Tier: Review Alternatives.
7. Non-Formulary (Reject 70): Review Alternatives.
8. Quantity Limit Exception (Reject 76): Create a [CD&A RM Task](#_Submitting_an_RM).
9. Step Therapy Exception (Reject 608 or Reject 75 AND 76 with reject messaging "Must Meet Step"): Create a [CD&A RM Task](#_Submitting_an_RM).

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| Decision Grid |

 Only file a First Call Resolution Grievance for plan design issues or for issues with the Coverage Determination process.

**CCRs will handle all calls as normal that are associated with the Coverage Gap, Catastrophic Stage, Inquiry, or ANOC issues.**

Upon receiving a call regarding a MED D prescription cost, non-formulary medication, or if a prior authorization is required, the CCR will:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Step** | **Action** | | | | | | |
| **1** | One moment while I access your profile and review the status of your prescriptions. | | | | | | |
| **2** | Refer to the appropriate CIF to determine who handles Coverage Determinations for the plan. | | | | | | |
| **If…** | **Then…** | | | | | |
| CVS Handles | Proceed to [Step 3](#DecisionGrid3). | | | | | |
| Client Handles | Proceed using the process outlined in the CIF. DO NOT create a CD&A RM Task. | | | | | |
| **3** | Determine if the beneficiary is in the Coverage Gap or Catastrophic Stage. Refer to [MED D - Determining TrOOP Status (020814)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=ace20931-df5c-49f8-9b4a-df89aade1fa5).  **Note:** If the call is disconnected and a Coverage Determination had been discussed, the representative should make 1 attempt to call the beneficiary back. Refer to [Disconnected, Dropped, No Caller (Ghost Calls), Spam, Automated, and Looping Calls (021760)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=480af287-dcb8-4305-84c5-dfe8e0c39312). If unable to reach the beneficiary, a RM Task should be submitted. | | | | | | |
|  | **If the beneficiary is…** | **Then…** | | | | | |
|  | In the Coverage Gap or Catastrophic Stage | * Beneficiaries in these stages need to be notified and educated by the CCR.   I see that you are currently in the <Coverage Gap OR Catastrophic Stage>. Let me tell you about the <Coverage Gap OR Catastrophic Stage> and how it impacts you.   * Proceed to the next step.   **Notes:**   * If the beneficiary states that they need a lower cost or asks for a Tiering Exception, confirm if the specific plan provides **enhanced benefits**.   + If yes, create a CD&A RM Task. See [Compass MED D - Coverage Gap Discount Program (062884)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=360780b1-6d69-4008-bc74-0d56018991e4). | | | | | |
|  | Not in the Coverage Gap or Catastrophic Stage | Proceed to the next step. | | | | | |
| **4** | Determine if a CD&A case is in process or has been completed by selecting the **Plan Benefit Override** button in **PeopleSafe**. | | | | | | |
| **If...** | **Then...** | | | | | |
| Yes | Proceed to [Step 5](#DecisionGrid5). | | | | | |
| No | Proceed to [Step 7](#DecisionGrid7). | | | | | |
| **5** | Select the radio button for the specific PA/Coverage Determination line in question and click the **View PA Status** button.    **Note:** If no radio button, select **View PA Status**. | | | | | | |
| **6** | Select the radio button in the **Prior Authorization and Appeals Status** section for the Prior Authorization or Appeal to review.  **Result:** The details, including (but not limited to) the **Status Description** and **Reason** will populate at the bottom of the screen.  **Note:** In the **Prior Authorization** **and Appeals Status** screen, the **Approval Thru** date may be incorrect. Always refer to the **Plan Benefit Overrides** screen to ensure that the correct expiration date of the override is provided.    **Note:** A resolved Grievance should be filed **only** if the beneficiary is upset about the **Coverage Determination process**.  **Note:** Decision letters can only be resent to the prescriber or beneficiary. If a beneficiary is asking for a CD&A case decision letter to be resent or has a special request regarding their letter font or language, create a [CD&A RM Task](#_Submitting_an_RM).   * Select the **Task Type**: Standard CD. * Indicate the following in the **RM Task Notes**:   + Reason for RM Task (resend letter, larger font, different language)   + Case number or medication for letter   + Beneficiary best call back number   + Address for letter | | | | | | |
|  | **If…** | **Then…** | | | | | |
|  | Status: Closed **AND** Resolution: Approved | Advise the beneficiary of the approval and next steps.    The Prior Authorization for <medication name> has been approved for <provide number of months> as of <effective date>. The medication will now process through the prescription benefit coverage. Please remember to ask the prescriber to renew the Prior Authorization again before <provide expiration date>.  Check for open orders under the **Mail Order** tab. If there is an open order:   * Proceed to assist the beneficiary in processing their order. * Advise the beneficiary of the approval dates and TAT for the order.   Check for rejected claims under the **Retail** tab. If there is a rejected claim:   * Ask the beneficiary if any claims have been paid out of pocket.   + If a claim has been paid out of pocket, educate the beneficiary on submitting a paper claim. Refer to [MED D - Researching and Submitting Paper Claims (112394)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=74dceac6-a55f-4504-ab6b-0866bb52c601) or, if it has been 7 days or less, offer to reach out to the pharmacy on the beneficiary’s behalf to reprocess the claim. * Advise the beneficiary that they will need to contact the retail pharmacy to reprocess the prescription claim with the current date (or the date the Prior Authorization was approved).   + If the beneficiary requests that the CCR perform the outreach, place the beneficiary on hold to make the outbound call to the pharmacy. If the beneficiary cannot hold, any outbound calls will need to be approved by your Supervisor.   **Notes:**   * A beneficiary may initiate a Coverage Determination or Redetermination renewal 90 days prior to it expiring. * A non-formulary medication that has been approved will not be eligible for a tiering exception. * Automatic PA extensions may be granted for a through date of next year (2024). This will be indicated in the **Plan Benefit Override Notes:** | | | | | |
|  | Status: Pending  **OR**  Resolution: In Process or Pending (including "ePA Pending Approval") | Review the member-facing notes and advise the beneficiary of the status  **Example:** Waiting for the prescriber to respond to the need for additional documentation for the case  Educate on expected timelines:  **Coverage Determination** requests can be either **standard** or **expedited**.   * **Standard Requests:** Decision within **72 hours** from date/time of receipt of valid request, but exception requests may be up to **408 hours** (17 days) if a statement of medical necessity is needed from the Prescriber.   + This includes nights, weekends and holidays. * **Expedited Requests:** Decision within **24 hours** from date/time of receipt of valid request, but exception requests may be up to **360 hours** (15 days) if a statement of medical necessity is needed from the Prescriber.   + This includes nights, weekends and holidays.   **Redetermination** requests can be either **standard** or **expedited**.   * **Standard Requests:** Decisions within **7 calendar days** from date/time of receipt of valid request.   + This includes nights, weekends and holidays. * **Expedited Requests:** Decisions within **72 hours** from date/time of receipt of valid request.   + This includes nights, weekends and holidays.   **CCR Notes:**   * If the request is standard and the beneficiary indicates they need the decision sooner than the expected timeline, create a new expedited RM Task. Refer to [Submitting an RM Task for CD&A](#_Submitting_an_RM). * If the beneficiary indicates they want to withdraw their open or pending request, see [Transfer to Coverage Determination (Escalations and Senior Team Only).](#_Transfer_to_Coverage) | | | | | |
|  | Status: Pending **OR** Resolution: In Process or Pending (including ePA Pending Answer) | Review the member-facing notes and advise the beneficiary of the status.  **Example:** Waiting for the prescriber to provide the necessary information to initiate the case.   * Create a [CD&A RM Task](#_Submitting_an_RM).   **CCR Notes:** ePA pending answer cases are requests started by the prescriber that have not been completed, so these cases are not yet valid. | | | | | |
|  | Status: Closed **AND** Resolution: Cancelled | Advise beneficiary of dismissed Coverage Determination.   * Review the **Member Oriented Status** and **Reason** descriptions to determine why the Coverage Determination was dismissed. * The beneficiary can resubmit or appeal the dismissal.   + If the beneficiary can satisfy the request (i.e., provide missing information), it will go through the standard Coverage Determination process.   + Submit a new CD&A RM Task if the beneficiary requests to resubmit or appeal.   **Note:** The Coverage Determination may still be denied after resubmitting or appealing the dismissal. At this point, the beneficiary would go through standard Redetermination process.  **CCR Note:** If member-oriented status states to contact CD&A, see [Transfer to Coverage Determination (Escalations and Senior Team Only).](#_Transfer_to_Coverage) | | | | | |
|  | Status: Closed **AND** Resolution: Denied | The beneficiary may file a Redetermination request or 1st Level of the Appeal Process.   * Your plan allows you to request an appeal within 65 days of the denied Coverage Determination. * You can submit a new Coverage Determination for a review of this medication to reset your appeals options if more than 65 days have passed since the Coverage Determination was denied. | | | | | |
|  |  | **If…** | | **Then…** | | | |
|  |  | * Non-Formulary * Tiering Exception | Educate the beneficiary on the denial using the **Member Oriented Status Description** in the **Plan Benefit Override** tab in **PeopleSafe**. **DO NOT** read the **Notes**; this is Clinical verbiage.  Your case was denied, and you will receive a letter that explains the reason for the denial and the next steps for appeal. | | | | |
|  |  |  | | **If…** | | **Then…** | |
|  |  |  | | * Beneficiary understands denial and is open to discussing alternatives   **OR**   * Has questions regarding alternatives | | * Review alternatives and other options that might be available. * Ensure that beneficiary decisions and education are outlined in notes. Refer to [MED D - Call Documentation Including Viewing and Adding Comments in PeopleSafe (067665)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=e9cdb772-9c04-4e42-b87a-ae4d2c2e1f62). | |
|  |  |  | | Beneficiary has **SPECIFICALLY** stated that:   * They want to file a Redetermination. * They have already been through the process of alternatives (already spoke with MD and alternatives are not viable). * They have questions about the denial. | | Create a [CD&A RM Task](#_Submitting_an_RM). | |
|  |  | * Prior Authorization * Quantity Limit * Step Therapy | Provide the beneficiary education on the denial using the **Member Oriented Status Description** in the **Plan Benefit Override** tab in **PeopleSafe**. **DO NOT** read the **Notes**; this is Clinical verbiage.    If the beneficiary has questions about the denial or wants to appeal the decision:  Your case was denied, and you will receive a letter that explains the reason for the denial and the next steps for appeal.   * **If no:** Ensure that beneficiary decisions and education are outlined in notes. Refer to [MED D - Call Documentation Including Viewing and Adding Comments in PeopleSafe (067665)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=e9cdb772-9c04-4e42-b87a-ae4d2c2e1f62). * **If yes:** Create a [CD&A RM Task](#_Submitting_an_RM). | | | | |
|  |  | Denied Redetermination | If the beneficiary has questions about the denial or wants to appeal the decision:  Your appeal was denied, and you will receive a letter that explains the reason for the denial and the next steps for appeal.   * **If no:** Ensure that beneficiary decisions and education are outlined in notes. Refer to [MED D - Call Documentation Including Viewing and Adding Comments in PeopleSafe (067665)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=e9cdb772-9c04-4e42-b87a-ae4d2c2e1f62). * **If yes:** Create a [CD&A RM Task](#_Submitting_an_RM). Select the **Task Type:** **Standard or Expedited Redetermination**. | | | | |
| **7** | * **SilverScript PDP Members ONLY:** Determine if the beneficiary is calling concerning the cost of a medication on the Tier Exception Exclusion List. Refer to [Med D - Tier Exception Exclusions - No Preferred Alternatives (010234)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=90c3c22e-86f7-46a9-934a-d5b17c67227d). * **All other members:** Proceed to [Step 8](#DecisionGrid8).   Health Plans have different formularies and it is possible the beneficiary may not be in the Coverage Gap, and medication is not eligible for a Tiering Exception. | | | | | | |
|  | **If the SilverScript PDP beneficiary is concerned about cost of…** | **Then…** | | | | | |
|  | A medication on the Tier Exception Exclusion List | I'm sorry to inform you that this drug currently has No Preferred Alternatives and is not eligible to be moved to a lower tier or cost. It would be my pleasure to provide you with some information regarding [financial assistance (026963)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=62aa67ac-8298-4fa1-b1ba-fda383d15b4c) if you’d like.   * If the beneficiary insists on a Tiering Exception, create a [CD&A RM Task](#_Submitting_an_RM). | | | | | |
|  | Another medication | Proceed to [Step 8](#DecisionGrid8). | | | | | |
| **8** | Determine the type of MED D Prescription question the beneficiary is inquiring about:  To verify the tier of a formulary medication in question:   * **SSI:** Go to aetnamedicare.com to locate the formulary. * **EGWP:** Go to Find Med D EOB / TF from 6-2020 (ONEclick) to locate formulary. * **NEJE:**   + For individual: Go to [www.RxMedicarePlans.com](http://www.RxMedicarePlans.com).   + For groups, go to the [Plan Design Highlights section of the CIF (022305)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=8f0c0855-9a84-4a06-b6cd-457703b3d870) and access the current year EGWP Matrix to view plan design and determine which formulary to view. Then go to <https://groups.rxmedicareplans.com/> to locate the appropriate formulary. * **All Other Plans:** Locate the formulary in the CIF under the Plan Design Highlights section.   Health Plans have different formularies and it is possible the beneficiary may not be in the Coverage Gap, and medication is not eligible for a Tiering Exception.  **DO NOT** use the **Formulary Tier** field on the **Prescription Details** screen in PeopleSafe to determine the Tier of a medication.  **Note:**   * If at any time the beneficiary is requesting an escalation, warm transfer to the [MED D Senior Resolution Team (Assist and Escalation Lines) (018060)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=d3ca13af-f894-45b7-b16a-f2cb777adf77). | | | | | | |
| **9** | Run a Test Claim and proceed to the Reject Code list.   * [Reject A5: Drug excluded by Med D Law](#MEDDLAW) * [Reject 70: Non-Formulary Issue](#REJECT70) * [No Reject Code: Concerns with Cost of Formulary Medication](#CostofForm) * [Reject 75: Prior Authorization](#Reject75) * [Reject 608 or Reject 75 AND Reject 76: Step Therapy](#StepTherapy) * [Reject 76: Quantity Limit Exception](#Reject76) * [Compounds](#Compounds) * [Specialty Medication](#Specialty) * [Reject A6: B vs D](#A6) * [Reject 925/88: Opioid](#Reject88) * [Paper Claim](#PaperClaimRequest)   **Note:** If a reject occurs on the primary and secondary plans, first follow the process outlined for the reject on the primary plan. | | | | | | |
|  | **Scenario…** | **Action…** | | | | | |
|  | Drug excluded by Med D Law  Reject A5  If Reject 70 displays with Reject A5, follow steps for Reject A5. | Educate the beneficiary that the drug is excluded by Med D Law:  This drug is currently excluded by Medicare Part D Law. We will need to identify if there are any potential alternatives available to you. | | | | | |
|  |  | **If…** | | | **Then…** | | |
|  |  | Beneficiary is interested in alternatives  **Note:** Some medications will not have alternatives. | | Please hold while I transfer you to our Clinical team to determine if there are any alternatives.  Transfer to the Clinical Care Services Team at **1-866-251-3591, Option 2** to identify alternatives. | | | |
|  |  | Beneficiary does not want alternatives or is unhappy with no other options | | File a Resolved Grievance in MHK or PeopleSafe if dissatisfaction was expressed.  **Documentation guidance:** The following needs to be documented in the Grievance file:   * Educated beneficiary that this is a Med D excluded drug and none of the exceptions were requested by the beneficiary.   **Note:** If this is an **inquiry** only, do NOT file a grievance. | | | |
|  |  | Beneficiary insists on an Exception | | Create a [CD&A RM Task](#_Submitting_an_RM).  **Note:** If beneficiary is insisting on Exception, **DO NOT** file a Grievance, and document actions in PeopleSafe. | | | |
|  | Non-Formulary medication  Reject 70  **Notes:**   * If Reject 70 displays with Reject A5, follow steps for Reject A5. * If Reject 76 displays with Reject 70, follow steps for Reject 70. * This also applies to a call related to an expired Non-Formulary exception. | Your drug is currently not included in your formulary. Please hold while I review alternatives and other options that might be available to you. | | | | | |
|  | Concerns with Cost of Formulary Medication  Not associated with a rejected claim  This also applies to a call related to an expired Tiering Exception. | a. Determine if the beneficiary is in the Coverage Gap, Deductible, or Catastrophic Stage. Refer to [MED D - Determining TrOOP Status (020814)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=ace20931-df5c-49f8-9b4a-df89aade1fa5).   * If the beneficiary **IS** in the Coverage Gap, Deductible, or Catastrophic Stage, educate the beneficiary:  I see you are currently in the <Coverage Gap OR Deductible OR Catastrophic Stage>. Let me explain what that means to you.   + Following the education, if the beneficiary insists on an Exception or a lower cost, proceed to the appropriate scenario below. * If the beneficiary **IS NOT** in the Coverage Gap, Deductible, or Catastrophic Stage, proceed to the appropriate scenario below.   Health Plans have different formularies and it is possible the beneficiary may not be in the Coverage Gap, and medication is not eligible for a Tiering Exception.  **SilverScript PDP Members ONLY:** Determine if the beneficiary is calling concerning the cost of a medication on the Tier Exception Exclusion List. Refer to [Med D – Tier Exception Exclusions – No Preferred Alternatives (010234)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=90c3c22e-86f7-46a9-934a-d5b17c67227d).   * If the medication **IS** on the Tier Exception Exclusion – No Preferred Alternatives list:   + Educate the beneficiary:  I'm sorry to inform you that this drug currently has No Preferred Alternatives and is not eligible to be moved to a lower tier or cost. It would be my pleasure to provide you with some information regarding [financial assistance (026963)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=62aa67ac-8298-4fa1-b1ba-fda383d15b4c) if you'd like.   + If the beneficiary insists on an Exception, create a [CD&A RM Task](#_Submitting_an_RM). * If the medication **IS NOT** on the Tier Exception Exclusion - No Preferred Alternatives list, proceed to the appropriate scenario below.   **Notes:**   * Always check the CIF to determine if beneficiary's Plan Benefit Design will provide a lower cost with a Tiering Exception. Do not file a Tiering Exception for the following situations:   + Medication rejecting as Non-Formulary   + A Specialty medication   + Lowest Cost Tier   + In the Coverage Gap or Deductible Stage (UNLESS a Tiering Exception will lower the tier and the beneficiary will no longer have to pay the deductible or coverage gap cost) * **DO NOT** transfer for a Tiering Exception if a non-formulary approval is already on file for the beneficiary for the same drug.   b. Proceed depending on the appropriate scenario: | | | | | |
|  |  | **Scenario** | | | | **Action** | |
|  |  | Lowest Cost Tier  **Notes:**   * Validate Tier structure using formulary and/or CIF. * For lowest cost tier medications, a Grievance Resolved should be filed in MHK or PeopleSafe due to dissatisfaction that the medication cost cannot be lowered. It is vital that the Grievance documentation indicates that it is for a lowest cost tier medication and does not qualify for an exception. | | | Educate the beneficiary on the Plan Benefit Design. This is the lowest cost copay.  In researching, I have identified your medication is currently at the lowest cost copay on the Plan. We will need to identify if there are any potential alternatives available to you. | | |
|  |  |  | | | | **If beneficiary…** | **Then…** |
|  |  |  | | | Is interested in alternatives | Please hold while I transfer you to our Clinical team to determine if there are any alternatives.  Transfer to the Clinical Care Services Team at **1-866-251-3591, Option 2** to identify alternatives. | |
|  |  |  | | | | Does not want alternatives or is unhappy with no other options | File a Resolved Grievance in MHK or PeopleSafe. |
|  |  |  | | | Insists on an Exception | Create a [CD&A RM Task](#_Submitting_an_RM).  **Note:** If the beneficiary is insisting on an Exception, **DO NOT** file a Grievance. Document all actions taken in PeopleSafe. | |
|  |  | Not Lowest Cost Tier, Not Specialty Tier | | | | In researching, I have identified your medication is a tiered drug so I will need to look for alternatives and any other options available to you.  **Note:**   * Do not offer a Tiering Exception unless the beneficiary specifically states “Tiering Exception” or requests a lower co-pay on their medication. | |
|  |  | Beneficiary asks to lower the cost of a medication and they are enrolled in a 1-tier plan (Client specific) | | | | Educate the beneficiary on the Plan Benefit Design.  In researching, I have identified your medication is currently at the lowest cost copay on the Plan. | |
|  |  | Specialty Tier Medication  **Note:** Specialty Medication (a medication that is on the [Caremark Specialty Drug List](https://www.caremark.com/wps/portal/!ut/p/c5/04_SB8K8xLLM9MSSzPy8xBz9CP0os3gnC3NzC-8gw1CXAB8DA08zY1cfD0MXYwM_c6B8pFm8AQ7gaIBPt4EBRLeje1hooIGzuZmBp7OJgadRWJi7r4eJoYG7GTF24zEdv24_j_zcVP2C3NDQiHJHRQDKE8oO/dl3/d3/L2dJQSEvUUt3QS9ZQnZ3LzZfQjg3NzhLUjFVRFBMMDBJNjNFTEgxRDMwVjY!/) or that PeopleSafe gives indication) does not necessarily mean it is a High Cost Specialty Tier. A Specialty medication may be on any Tier on the Plan formulary and may be eligible for a Tiering Exception.  For Specialty medication:   * Access the Plan's formulary document. * Determine the Tier. * Follow the appropriate process located within this grid for that Tier. | | | * Educate the beneficiary on the Plan Benefit Design.   **Note:**   * Do not offer a Tiering Exception unless the beneficiary specifically states “Tiering Exception” or requests a lower co-pay on their medication. | | |
|  | Prior Authorization  Reject 75 | Your drug requires a prior authorization. I am going to create a request to initiate the coverage determination process. When I create a request, you will receive a decision regarding your medication from CVS Caremark.  Create a [CD&A RM Task](#_Submitting_an_RM). | | | | | |
|  | Step Therapy Exception  Reject 608 or Reject 75 AND Reject 76 with reject messaging "Must Meet Step" | Your drug requires a step therapy exception. I am going to create a request to initiate the coverage determination process. When I create a request, you will receive a decision regarding your medication from CVS Caremark.  Create a [CD&A RM Task](#_Submitting_an_RM). | | | | | |
|  | Quantity Limit Exception  Reject 76  If Reject 76 displays with Reject 70, follow steps for Reject 70.  Reject AG (Days Supply Limitation For Product/Service) may look similar to Reject 76 but are NOT the same. DO NOT use this step if Reject Code AG is given. | Your drug requires a quantity limit exception. I am going to create a request to initiate the coverage determination process. When I create a request, you will receive a decision regarding your medication from CVS Caremark.  Create a [CD&A RM Task](#_Submitting_an_RM). | | | | | |
|  | Compounds  Reject 70 (and potentially others depending on ingredients) | Create a [CD&A RM Task](#_Submitting_an_RM). Notate it is a Compound in the **Notes** section of the RM Task.  **Note:** There are no alternatives; an RPh must review. | | | | | |
|  | Specialty Medication | Determine the scenario:  **Exception:** Carefirst: Always warm transfer Specialty calls. | | | | | |
|  |  | **Scenario…** | | | **Action…** | | |
|  |  | Copay, Mail Order, General Questions | | | Conference in the Specialty Care team for assistance at 800-237-2767. | | |
|  |  | Alternatives or Clinical Questions | | | Conference in the Specialty Pharmacist for assistance at 800-308-1977, Option 3, Option 2. | | |
|  |  | If alternatives are not available and beneficiary requests exception | | | Create a [CD&A RM Task](#_Submitting_an_RM). | | |
|  | B vs. D Prior Authorization  Reject A6 | Your drug requires a prior authorization. I am going to create a request to initiate the coverage determination process. When I create a request, you will receive a decision regarding your medication from CVS Caremark.  Create a [CD&A RM Task](#_Submitting_an_RM).  **Note:** Beneficiaries should refer to their Part B plan or have a conversation with their MD on how s/he is responding (Dx code) on the need for the medication before submitting a redetermination. This applies to redetermination only, not the first time the beneficiaries make a request for B vs D. | | | | | |
|  | Opioid  Reject 925/88 PPSREQD | * Educate the beneficiary on options for the restrictions – refer to [MED D - FAQs - Opioid Changes (Reject 925 and 88) (013567)](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=ccd35909-9dbe-4add-8241-c10b6dc83109). * If beneficiary indicates they have received a letter stating they are potentially subject to this restriction, refer to [MED D - Member Specific Utilization Management Edit (MSUME) (068281)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=00b27326-f9ba-47b2-912e-b038490eb069)   **Note:** Restrictions may be in place for one or more of the following:   * Day Supply * Pharmacy Lock * Prescriber Lock   Refer to [MED D - FAQs - Opioid Changes (Reject 925 and 88) (013567)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=ccd35909-9dbe-4add-8241-c10b6dc83109) for guidance.  If beneficiary has received restrictions on opioids and would like to initiate a CD, create a [CD&A RM Task](#_Submitting_an_RM). | | | | | |
|  | Paper Claim Request  **Example:** Billed for a medication while receiving outpatient surgery | * Perform a fulfillment task to send a paper claim form. Refer to [MED D - Researching and Submitting Paper Claims (112394)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=74dceac6-a55f-4504-ab6b-0866bb52c601). * Review the **Beneficiary Disputes Reimbursement Amount on Rx** section in [MED D - Researching and Submitting Paper Claims (112394)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=74dceac6-a55f-4504-ab6b-0866bb52c601). * Educate beneficiary on reimbursement rate. | | | | | |
| **10** | Ensure that the beneficiary response and education are documented in the notes. Refer to [MED D - Call Documentation Including Viewing and Adding Comments in PeopleSafe (067665)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=e9cdb772-9c04-4e42-b87a-ae4d2c2e1f62). | | | | | | |
| **Scenario…** | **Required Documentation…** | | | | | |
| Non-Formulary Drugs | Reviewed Alternatives. | | | | | |
| Lowest Cost Tier Formulary Drugs | * Educated beneficiary <drug name> is on lowest cost tier of plan. * Beneficiary's response/action:   + Interested in alternatives - transferred to Clinical Care   **OR**   * + Declined alternatives/unhappy with no options - Filed a Resolved (First Call Resolution) Grievance. | | | | | |
| Not Lowest Cost Tier, Not Specialty Tier Formulary  Drugs | Review alternatives. | | | | | |
| Specialty Tier Formulary Drugs | Review alternatives. | | | | | |
| * Quantity Limit * Step Therapy * Prior Authorization | Create a [CD&A RM Task](#_Submitting_an_RM). | | | | | |

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| Transfer to Coverage Determination (Escalations and Senior Team Only) |

Follow the below steps:

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| **Step** | **Action** |
| **1** | Determine the reason for the call requires assistance from the Senior Escalation Team. |
| **2** | **Warm transfer** to the Senior Escalation Team and advise of the scenario requiring the transfer:   * Beneficiary is escalated and insistent on being transferred to the CD&A Team * Case Notes indicate to contact the CD&A Team for more information on the request. * Beneficiary calls with approval on file, but medication still rejecting at the pharmacy. * Beneficiary wants to withdraw a case that is open or pending. * Beneficiary calls with a change in provider/prescriber for an in-progress case * Beneficiary returning outbound call from CD&A Team * Client Representative/Benefit Office wants to speak to CD&A on behalf of the beneficiary.   **Notes:**   * When warm transferring, be prepared to provide your first name, first initial of last name, and CID/ZID/UID to the MED D Coverage Determination and Appeals (CD&A) Department. * After hours, submit an RM task. Refer to [Submitting an RM Task for CD&A](#_Submitting_an_RM). |

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| Submitting an RM Task for CD&A |

May vary by client; always refer to the CIF.

**Note:** Review the View Activity screen to confirm a CD&A RM Task is not already in process for the same medication.

 Each medication requested will require a separate RM task.

Complete the steps below:

|  |  |  |  |  |
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| **Step** | **Action** | | | |
| **1** | Determine which of the following apply while attempting to create a CD&A RM Task. | | | |
| **If…** | **Then…** | | |
| Caller **does not** want to initiate request now | Proceed to [Step 2](#SubmittingStep2). | | |
| Caller **does** want to initiate the request now | Proceed to [Step 3](#SubmittingStep3). | | |
| **2** | Determine if the caller is the beneficiary (or beneficiary's representative) or is a physician/other prescriber. | | | |
| **If…** | **Then…** | | |
| **Start the request later** and is a **beneficiary** or **beneficiary's representative (AOR or POA is on file)** | In order to make sure I understand correctly, you would like to wait and begin your request at a later time? | | |
| **If…** | | **Then…** |
| Yes | | * I understand. * Please feel free to contact us at your earliest convenience 24 hours a day, 7 days a week. * You can find the number on the back of your ID card.   + **Process Note:** Look up the specific client Care number on the CIF. * Completed Coverage Determination forms can also be faxed or mailed to:   **Fax:**  MED D Coverage Determination and Appeals (CD&A)  Fax #: **1-855-633-7673**  **Mail:**  CVS Caremark Part D Services  Coverage Determinations & Appeals  P.O. Box 52000  MC109  Phoenix, AZ 85072-2000   * You may also utilize your plan's website, which contains a Coverage Determination request form and tells you how to submit the request electronically, if you prefer.   Proceed to [Step 6](#SubmittingStep6). |
| No | | I will be happy to send your request so that it can be reviewed by the Coverage Determination Department.  Proceed to [Step 3](#SubmittingStep3). |
| **Start the request later** and is a **Physician** or **other Prescriber** | In order to make sure I understand correctly, you would like to wait and begin your request at a later time? | | |
| **If…** | | **Then…** |
| Yes | | * I understand. * Please feel free to contact us at your earliest convenience. * You can contact MED D Coverage Determination and Appeals (CD&A) for Coverage Determination requests at **1-877-827-7315 and select prompt 2**.   **CCR Note:** Do not provide the above telephone numbers to a beneficiary. They are for provider and prescriber calls only.   * Completed Coverage Determination forms can also be faxed or mailed to:   **Fax:**  MED D Coverage Determination and Appeals (CD&A)  Fax #: **1-855-633-7673**  **Mail:**  CVS Caremark Part D Services  Coverage Determinations & Appeals  P.O. Box 52000  MC109  Phoenix, AZ 85072-2000   * You may also utilize the plan's website, which contains a Coverage Determination request form and tells you how to submit the request electronically, if you prefer.   Proceed to [Step 6](#SubmittingStep6). |
| No | | I will be happy to send your request so that it can be reviewed by the Coverage Determination Department.  Proceed to [Step 3](#SubmittingStep3). |
| **3** | Determine if the request is **standard** or **expedited**. Requests should always be labelled as **standard** unless the beneficiary or physician indicates the request should be expedited.  To determine if **expedited** task is needed, listen for the following phrases:   * Patient is out of medication. * Patient will be hospitalized or die if they do not receive the medication. * Need medication in 24 hours or today/tomorrow * Expedite * Urgent * Immediate * Stat * Emergency * Exigent   **REMINDER:** Sending the task is considered an **Oral Request**. | | | |
| **If the request is…** | **Then…** | | |
| Standard | Submit the following RM task:  Each medication requested will require a separate RM task.  **Task Category:** Medicare D - CD/PA/Appeals  **Task Type:**   * For Coverage Determination: Standard Coverage Determination/PA * For Redetermination: Standard Redetermination   **Queue:** Medicare D - CD/Appeals  **REQUIRED RM Task Fields:**   * Plan ID * Contract ID * Participant Address * Participant Phone Number (Area Code – Phone - Extension) * Prescriber Name * Prescriber Phone Number (Area Code – Phone - Extension)   **You MUST ask the caller for Prescriber Name, Phone, and Fax Number and document them in the RM Task.** If the caller cannot provide at least the Prescriber Name and Phone Number, do not submit the RM Task. Advise the caller that we cannot proceed with the request.   * Drug Label (Medication Name) * Receive Date of Appeal (Date of Request)   **Notes Field:**  The following information is required:  **Prescriber Name, Phone, and Fax Number (if available).** If the caller cannot provide the Prescriber Name and Phone Number, we cannot proceed with the request.   * If a beneficiary has a Coverage Determination request for 2025 eligibility, add the following note to the PeopleSafe RM Task: “**This request is for 2025**”. For the dates that 2025 requests can be submitted, refer to [MED D - Coverage Determination Requests for 2025 (069924)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=2c7ceccc-bde6-4ec4-87d8-de77a64c7697). * The oral request in writing **(in the** **requestor's own words**) * Quantity and Day Supply for the medication * Reject Code for the medication. Refer to [Decision Grid](#_Decision_Grid).   **REMINDER:** Complete **ALL** required fields that are marked with an **asterisk (\*)**. Complete additional RM Task fields with information as provided.  Proceed to the next step. | | |
| Expedited | Submit the following RM task:  Each medication requested will require a separate RM task.  **Task Category:** Medicare D - CD/PA/Appeals  **Task Type:**   * For Coverage Determination: Expedited Coverage Determination/PA * For Redetermination: Expedited Redetermination   **Queue:** Medicare D - CD/Appeals  **REQUIRED RM Task Fields:**   * Plan ID * Contract ID * Participant Address * Participant Phone Number (Area Code – Phone - Extension) * Prescriber Name * Prescriber Phone Number (Area Code – Phone - Extension)   **You MUST ask the caller for Prescriber Name, Phone, and Fax Number and document them in the RM Task.** If the caller cannot provide at least the Prescriber Name and Phone Number, do not submit the RM Task. Advise the caller that we cannot proceed with the request.   * Drug Label (Medication Name) * Receive Date of Appeal (Date of Request)   **Notes Field:**  The following information is required:  **Prescriber Name, Phone, and Fax Number (if available).** If the caller cannot provide the Prescriber Name and Phone Number, we cannot proceed with the request.   * If a beneficiary has a Coverage Determination request for 2025 eligibility, add the following note to the PeopleSafe RM Task: “**This request is for 2025**”. For the dates that 2025 requests can be submitted, refer to [MED D - Coverage Determination Requests for 2025 (069924)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=2c7ceccc-bde6-4ec4-87d8-de77a64c7697). * The oral request in writing **(in the requestor's own words**) * Quantity and Day Supply for the medication * Reject Code for the medication. Refer to [Decision Grid](#_Decision_Grid).   **REMINDER:** Complete **ALL** required fields that are marked with an **asterisk (\*)**. Complete additional RM Task fields with information as provided.  Proceed to the next step. | | |
| **4** | Repeat the entire request back to the caller to confirm accuracy.  This is a **mandatory** step and is **required** to be performed  **Note:** If the call is disconnected and a Coverage Determination had been discussed, the representative should make 1 attempt to call the beneficiary back. Refer to [Disconnected, Dropped, No Caller (Ghost Calls), Spam, Automated, and Looping Calls (021760)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=480af287-dcb8-4305-84c5-dfe8e0c39312). If unable to reach the beneficiary, an RM Task should be submitted. | | | |
| **5** | Advise the caller that:   * The request has been sent to the MED D Coverage Determination and Appeals (CD&A) Team. * The **Beneficiary or Beneficiary's representative** will be notified of the decision by an automated phone call (if valid phone number is on file) and/or a letter in the mail. * The **prescriber** will be notified by a fax and/or a letter in the mail.   **PROCESS NOTE:** Verify that an accurate phone number is on file and process an update if necessary.   * Refer to [MED D - Address Changes and Out of Area (OOA) (030149)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=0ba6dea9-4b34-4351-b06a-ec81046f6c0f).   The time frames to complete the **Coverage Determination** process are:   * **Standard:** Up to **72 hours** from date/time of receipt of valid request, but exception requests may be up to **408 hours** (17 days) if a statement of medical necessity is needed from the Prescriber.   + This includes nights, weekends and holidays. * **Expedited:** Up to **24 hours** from date/time of receipt of valid request, but exception requests may be up to **360 hours** (15 days) if a statement of medical necessity is needed from the Prescriber.   + This includes nights, weekends and holidays.   The time frames to complete the **Redetermination** process are:   * **Standard Requests:** Decisions within **7 calendar days** from date/time of receipt of valid request.   + This includes nights, weekends and holidays. * **Expedited Requests:** Decisions within **72 hours** from date/time of receipt of valid request.   + This includes nights, weekends and holidays. | | | |
| **6** | Ask if there are any other benefit questions. | | | |
| **If…** | | **Then…** | |
| Yes | | * Address any benefit issues. * Document and close the call according to existing policies and procedures.   **Note:** Refer to [MED D - Call Documentation Including Viewing and Adding Comments in PeopleSafe (067665)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=e9cdb772-9c04-4e42-b87a-ae4d2c2e1f62). | |
| No | | Document and close the call according to existing policies and procedures.  **REMINDER:** Document when a caller declines initiating a Coverage Determination.  **Note:** Refer to[MED D - Call Documentation Including Viewing and Adding Comments in PeopleSafe (067665)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=e9cdb772-9c04-4e42-b87a-ae4d2c2e1f62). | |

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| FAQs |

Refer to the table below:

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| --- | --- | --- |
| **#** | **Question** | **Answer** |
| **1** | **What is a Prior Authorization and why is the plan requesting one?** | For certain prescription drugs, the beneficiary needs to get approval from the plan before the plan will agree to cover the drug. In order to start the review process, the beneficiary or their prescriber must submit a Prior Authorization (PA) request. Drugs that require a PA are listed on the Formulary. This process is not intended to cause inconvenience, but rather to ensure medications receive the highest in safety and quality monitoring. It is not necessary to have a prescription on file to initiate a request for a formulary or non-formulary medication requiring a PA. |
| **2** | **Does a beneficiary need a prescription on file to process a Coverage Determination?** | No, a prescription does not determine or affect if a medication is covered by the plan. A prescription is needed to receive the medication from the pharmacy, but not to review a coverage determination. |
| **3** | **What do I do if a medication rejects 70 and 76?** | Refer to the document above and follow the steps for reject 70. |

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| Log Activity |

Refer to [Log Activity/Capture Activity Codes (005164)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=bdac0c67-5fee-47ba-a3aa-aab84900cf78).

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| Related Documents |

* [MED D - Appointment of Representative (AOR) Form (096099)](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=577a556f-330c-4ea1-b1c6-200d85b736cf)
* [Medicare Prescription Drug Coverage and Your Rights (018576)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=ca887eaf-6d6b-4d2a-be9e-90d80b1c77cb)
* [MED D - Grievance vs. Coverage Determination – Decision Matrix (027480)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=06e8f82d-e7b7-4a60-9c81-3bf7c37aadbf)

* [MED D - Coverage Determination Requests for 2025 (069924)](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=2c7ceccc-bde6-4ec4-87d8-de77a64c7697)

**Parent Document:** [CALL-0048: Medicare Part D Customer Care Call Center Requirements-CVS Caremark Part D Services, L.L.C.](https://policy.corp.cvscaremark.com/pnp/faces/DocRenderer?documentId=CALL-0048)

**Abbreviations/Definitions:** [Customer Care Abbreviations, Definitions and Terms Index (017428)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=c1f1028b-e42c-4b4f-a4cf-cc0b42c91606)

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