OMB Approval No. 0938-0976
(Expires 02/29/2020)

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

[Logo]

NOTICE OF DENIAL OF MEDICARE PART D PRESCRIPTION DRUG COVERAGE

Date:	
Enrollee's Name:	Member Number:

Your request was denied
We have denied coverage or payment under your Medicare Part D benefit for the following prescription drug(s) that you or your prescriber requested:

Why did we deny your request?
We denied this request under Medicare Part D because {Provide specific rationale for the denial, including any applicable Medicare coverage rule or Part D plan policy. See instructions for additional detail.}:

You should share a copy of this decision with your prescriber so you and your prescriber can discuss next steps. If your prescriber requested coverage on your behalf, we have shared this decision with your prescriber.

[Language to be inserted, as applicable, for prescription drugs that are or may be covered under Medicare Parts A or B]:

[Medicare Advantage plans that also provide Part D coverage (MA-PDs):] {*This request was denied under your Medicare Part D benefit; however, coverage/payment for the requested drug(s) has been approved under Medicare Part A/B* {explain the conditions of approval in a readable and understandable format}. *If you think Medicare Part D should cover this drug for you, you may appeal.*}

[Standalone Part D plans (PDPs):] {*This request was denied under your Medicare Part D benefit; however, it may be covered under Medicare Part A or Part B. For more information, talk to your prescriber or call 1-800-MEDICARE.* }

What If I Don't Agree With This Decision?
You have the right to appeal. If you want to appeal, you must request your appeal within 60 calendar days after the date of this notice. We can give you more time if you have a good reason for missing the deadline. You have the right to ask us for a **formulary exception** if you believe you need a drug that is not on our list of covered drugs (formulary). You have the right to ask us for a **coverage rule exception** if you believe a rule such as prior authorization or a quantity limit should not apply to you. You can either provide information that shows that you meet the coverage rule that applies to the drug you are requesting or you can ask for a coverage rule exception. You can ask for a **tiering exception** if you believe you should get a drug at a lower cost-sharing amount. Your prescriber must provide a statement to support your exception request.

Who May Request an Appeal?
You, your prescriber, or your representative may request an expedited (fast) or standard appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to be your representative. Others may already be authorized under State law to be your representative.

You can call us at: ( )_____to learn how to appoint a representative. If you have a hearing or speech impairment, please call us at TTY: ( )_____.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

There Are Two Kinds of Appeals You Can Request

Expedited (72 hours): You, your prescriber, or your representative can request an expedited (fast) appeal if you or your prescriber believe that your health could be seriously harmed by waiting up to 7 days for a decision. You cannot request an expedited appeal if you are asking us to pay you back for a prescription drug you already received. If your request to expedite is granted, we must give you a decision no later than 72 hours after we get your appeal.

- **If your prescriber** asks for an expedited appeal for you, or supports you in asking for one, and indicates that waiting for 7 days could seriously harm your health, **we will automatically expedite your appeal.**

- If you ask for an expedited appeal without support from your prescriber, we will decide if your health requires an expedited appeal. We will notify you if we do not give you an expedited appeal and we will decide your appeal within 7 days.

Standard (7 days): You, your prescriber, or your representative can request a standard appeal. We must give you a decision no later than 7 days after we get your appeal. If your appeal is for payment of a drug you've already received, we'll give you a written decision within 14 days.

What Do I Include with My Appeal Request?
You should include your name, address, Member number, the reasons for appealing, and any evidence you wish to attach. Remember, your doctor must provide us with a supporting statement if you're requesting an exception to a coverage rule. You should include information about why the coverage rule should not apply to you because of your specific medical condition. If your appeal relates to a decision by us to deny a drug that is not on our formulary, your prescriber must indicate that all the drugs on any tier of our formulary would not be as effective to treat your condition as the requested off-formulary drug or would harm your health.

How Do I Request an Appeal?

For an Expedited Appeal: You, your prescriber, or your representative should contact us by telephone or fax at the numbers below:

Phone:

Fax:

For a Standard Appeal: You, your prescriber, or your representative should mail or deliver your written appeal request to the address below:

{Insert address}

What Happens Next?
If you appeal, we will review your case and give you a decision. If any of the prescription drugs you requested are still denied, you can request an independent review of your case by a reviewer outside of your Medicare Drug Plan. If you disagree with that decision, you will have the right to further appeal. You will be notified of your appeal rights if this happens.

Get help & more information

- {Plan Name} Toll Free: TTY users call:
  {Insert call center hours of operation}
  {Insert plan website}
- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users call: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050
- Elder Care Locator: 1-800-677-1116
- State Health Insurance Program National Technical Assistance Center: 877-839-2675

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CMS does not discriminate in its programs and activities: To request this form in an accessible format (e.g., Braille, Large Print, Audio CD) contact your Medicare Drug Plan. If you need assistance contacting your plan, call: 1-800-MEDICARE.