DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

~~**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 under the section titled "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**~~**Coverage for your drug 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:~~ We denied coverage under Medicare Part D for the following drug(s) you or your prescribing provider asked for

~~**Why did we deny your request**~~**Why was coverage for this drug denied~~?~~?**
We denied coverage for this drug because ~~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 s~~Share a copy of this decision with your prescrib~~er~~ing provider and ~~er so you and your prescriber can~~ discuss next steps. If your prescrib~~er~~ing ~~requested~~asked for coverage on your behalf, we ~~have~~already shared this denial ~~decision with~~notice with ~~your prescriber~~them.

[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.~~

You have the right to appeal this decision

You have the right to ask us to review our decision by asking us for an appeal within 65 calendar days of the date of this notice. If you ask for an appeal after 65 days, you must explain why your appeal is late.

You or your prescribing provider have the right to ask us for a special type of appeal called an **"exception."** Your prescribing provider must provide a statement to support your exception request. Examples of an exception are:

- **Formulary exception:** you need a drug that's not on our list of our covered drugs (formulary).
- **Coverage rule exception:** you think a coverage rule (like prior authorization or a quantity limit) shouldn't apply to you for medical reasons.
- **Tiering Exception:** you need to take a non-preferred drug that's on a higher cost-sharing tier, and you want our plan to cover the drug at a lower cost-sharing amount.

Who ~~May~~ can ask for~~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. To learn how to appoint a representative call us at: ( )_____~~---------to learn how to appoint a representative. If you have a hearing or speech impairment, please call us at~~ TTY users can call: ( )_____~~----------~~.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

There Are ~~Two~~ 2 Kinds of Appeals standard or expedited (fast)~~You Can Request~~

Standard appeal: you'll get a written decision within 7 days (or 14 days if your appeal is about a payment for a drug you already received).

Expedited appeal (fast): you'll get a written decision within 72 hours.

- You can ask for an expedited (fast) appeal when you or your prescribing provider believe that your health could be seriously harmed by waiting for a standard decision.
- You can't ask for an expedited appeal if you're asking us to pay you back for a drug you already received.
- We'll automatically expedite your appeal if your prescribing provider asks for one for you (or supports your request) and indicates that waiting for a standard decision could seriously harm your health. If you ask for an expedited appeal without support from your prescribing

provider, we'll decide if your health requires an expedited appeal. If we don't give you an expedited appeal, we'll process a standard appeal.

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.

How to ask for an appeal

For an **expedited** (fast) appeal, phone is the fastest way to ask:

- Phone: TTY:

For a **standard** appeal: [For plans that accept verbal standard requests:] {*You can file an appeal by phone, by fax, online, or by mailing a letter to the address below.*}
[For plans that don't accept verbal standard requests:] {*You can file an appeal by fax, online, or by mailing a letter to address below.*}

[For plans that don't accept verbal standard requests, omit the plan phone number and TTY]

{*Phone:*}
{*TTY:*}
Fax:
Online:
Address:

What ~~Do I~~ to Iinclude with ~~My~~your ~~A~~appeal ~~R~~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

- Your name, address and member number
- The reasons you're appealing
- Any evidence you want to attach to support your case
- Supporting statement from your prescribing provider

How Do I Request an Appeal?

For an Expedited (Fast) Appeal: You, your prescriber, or your representative can file an appeal by telephone, by fax, through the plan's website, or by mail. **A verbal request by telephone is the fastest way to file an expedited (fast) request.**

Phone:

TTY:

For a Standard Appeal: [For plans that accept verbal standard requests:] {*You, your prescriber, or your representative can file an appeal by telephone, by fax, through the plan's website, or by sending a letter to the mailing address listed below.*}
[For plans that do not accept verbal standard requests:] {*You, your prescriber, or your representative can file an appeal by fax, through the plan's website, or by sending a letter to the mailing address listed below.*}

[For plans that do not accept verbal standard requests, omit the plan phone number and TTY]

{*Phone:*}

{*TTY:*}

Fax:

Plan Website:

Address:

What Happens Next?
After your appeal, we'll If you appeal, we will review your case and give you a decision. If any of the prescription drugs you requestedasked for are still denied, you can ask for the next level of review, which is an request an independent review of your case by a reviewer outside of your Medicare Drug Pplan. If you disagree with that decision, you willyou'll have the right to further appeal. You wilYou'll 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 (1-888-466-9050)
- Elder Care Locator: 1-800-677-1116 or Eldercare.acl.gov/Public/Index.aspx to find help in your community
- State Health Insurance Program : call your State Health Insurance Assistance Program for free personalized health insurance counseling. Visit SHIPhelp.org or call National Technical Assistance Center: 1 - 877-839-2675 to get the number for your local SHIP.

Get information in another format

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this collection is 0938-0976. This notice collection is for the notice Medicare drug plans must provide with a request for a drug is denied. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. This information collection is mandatory under Section 1860D-4(g)(h) of the Act and the regulatory authority set in Subpart M of Part 423 at 42 CFR 423.568 and, 423.572. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

~~You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.~~