Request for Medicare Prescription Drug Appeal

This form can be used to request an appeal of denied coverage for a prescription drug, payment (a claim) for a prescription drug, or a denied request for an exception to your plan's formulary. This form can also be used to appeal when your plan has missed timeframes for giving you or your doctor a decision related to your prescription drug coverage.

Enrollee's/Requestor's Information

______________________________ ______________________________
Enrollee's Name | Enrollee's Date of Birth

______________________________ ______________________________
Enrollee's Medicare Number | Enrollee's Part D Plan ID Number

____
Requestor's Name (if not enrollee)

Requestor's relationship to Enrollee (attach documentation that shows authority to represent enrollee, if other than prescribing physician)

Enrollee/Requestor's Address

(____)__________________
Phone

Describe your appeal, including name of prescription drug (if known, include strength, quantity and quantity requested per month)

Prescribing Physician's Information

______________________________ ______________________________
Name | Medical Specialty

____
Address | City | State | Zip Code

(____)__________________ (____)__________________ ______________________________
Work Phone | Fax | Office Contact Person

M0031_NAE09O_2037
CMS Approved 0509

Type of Appeal (Redetermination)

☐ I am appealing a denial of an exception to the plan's formulary. I want the plan to reconsider my/my physician's request to use a non-formulary drug.

☐ I am appealing a denial of an exception to the plan's formulary because the plan changed its formulary and removed my drug from its list. I want the plan to reconsider my/my physician's request to continue using my drug even though it is no longer on the formulary.

☐ I am appealing a denial of my request that I skip the plan's requirement to try one or more other drugs before approving the drug I need. I want the plan to reconsider my/my physician's request for an exception to what is call "step therapy."

☐ I am appealing a denial of my/my physician's request that I skip the plan's requirement for a prior authorization for the drug I need.

☐ I am appealing a denial of my request that I skip the plan's limit on the number of pills I can receive so that I can get the number of pills my doctor prescribed. I want the plan to reconsider my/my physician's request for an exception to what is call "quantity limits."

☐ I am appealing a denial of my request to pay a lower copayment amount. I/my doctor believe I must take a drug in a higher tier.

☐ I am appealing a denial of my request to pay a lower copayment amount. A drug I am using is being or was moved to a high copayment tier in a formulary change.

☐ I am appealing a denial of a claim for a prescription drug that I paid for out of pocket.

Additional information that should be considered (attach any supporting documents including, if possible, additional information from your physician):

If you or your physician believes that waiting for a standard decision (which is provided within 7 days) could seriously harm your health, life, or ability to regain maximum function, you may request an expedited (fast) decision. If your physician provides support for a fast decision, we will give you a decision within 24 hours. If you do not obtain your physician's support, we will decide if your health condition requires a fast decision.

☐ I need an expedited redetermination. (attach physician's supporting statement, if applicable)

____________________________________ _______________________
Beneficiary/Requestor's Signature Date

Send this request to **Care Improvement Plus, Attn. Pharmacy Appeals, 351 W. Camden St. Suite 100, Baltimore, MD 21201 or Fax to 1-866-683-3272.** Note that your health plan may require additional information. See your plan benefit materials for more information.